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Letter to the Editor

Delayed CT head in elderly blunt head trauma patients taking antithrombotics

It was with great interest that we read the article by Scantling and colleagues [1]. The question of the interest of delayed computed tomography (CT) of the head (D-CTH) in elderly patients under antithrombotic medications with intracranial haemorrhage visualized at the first CT of the head is a very relevant question from an epidemiological point of view, with the ever-increasing number of this kind of patients who fall, and from a socioeconomic level for determining the health care costs for the patient or the society, as is well-explained by Scantling et al. in their discussion. The French recommendations [2] concerning the monitoring of patients under antithrombotics following a mild head injury strongly encourage a second D-CTH scan be performed between 12 and 24 h after trauma. So, we wonder if the precocity of D-CTH (before 12 h) in Scantling et al.'s work [1] could not decrease the number of intracranial haemorrhage progressions. Indeed, Versmee et al. [3] showed a cohort of 419 patients with a delayed haemorrhage rate of 2% seen only on a CT scan of the head done at 24 h. In addition, the results of Scantling et al. of that the progression of intracranial haemorrhage does not differ according to the type of antithrombotic seems to be a mistake to us if we compare anticoagulants (e.g., warfarin, dabigatran, rivaroxaban) to antiplatelet therapy (e.g., aspirin, clopidogrel). We built a table (see Table 1) with Scantling et al.'s data and performed a chi-squared test, which elucidated a progression of haemorrhage that is statistically greater in patients treated with anticoagulants than in those treated with antiplatelet therapy ($p = 0.047$). This result is not surprising and is along the same lines of a recent work [4]. Chiu et al. showed that mortality due to a fall in anticoagulated patients was three times higher as compared with that in nonanticoagulated patients probably due to fall recurrences (5%). The pillar of the management of haemorrhage under anticoagulant therapy remains reversal of these. As a result, we know that antagonist treatment administration and its early introduction are among the most valuable factors in stopping the progression of initial intracranial haemorrhage [5]. We believe that the antagonist treatment described in the original article [1] is not precise enough and does not allow the reader to know if, for example, patients under warfarin benefited from vitamin K including at which doses nor about the delay to introduce it. In the same way, we have no idea about the control of antagonist treatment efficacy and a possible second administration. We would like to thank the authors for their quality work. Nevertheless, it seems to us that it is premature to rule out D-CTH from the diagnostic strategy based on the arguments presented in Scantling et al.'s study, especially for patients being treated with oral anticoagulants.

Table 1
Elderly patients using antithrombotic medications divided by type of antithrombotic used and whether or not the delayed CT of the head was worsened or stable/improved.

Antithrombotic	Warfarin/dabigatran/rivaroxaban N = 32	Aspirin/clopidrogrel N = 134	*p*
Worsened intracranial hemorrhage	N = 16 (50%)	N = 42 (31,3 %)	0,047
Stable/improved intracranial hemorrhage	N = 16 (50%)	N = 92 (68,7 %)	

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