Comparison of clinical outcomes between anteroposterior and lateral penetrating craniocerebral gunshot wounds

Y Izcı, H Kayali, M Daneyemez, T Koksel

PATIENTS AND METHODS

In total, 22 consecutive patients with supratentorial PCGW underwent surgical management over a 10 year period. All the patients were male, mean age 22 years (range 20–30). Of the 22 patients, 15 (68%) were injured during conflict, 5 (23%) were suicide attempts and 2 (9%) were injured accidentally. A bullet was the wounding agent in 12 (55%) patients and shrapnel in 10 (45%).

Injury was anteroposterior in 16 patients (73%) and lateral in six (27%). The wounding agent was a bullet in eight of the (50%) of 16 patients with anteroposterior injury and shrapnel in the remaining eight patients. In the group with lateral injury, the wounding agent was a bullet in four cases (67%) and shrapnel in the other two.

Mean GCS score on admission was 9 (range 3–15). The GCS score for each group is shown in table 1. Of 16 patients with anteroposterior injury, 10 (63%) had a GCS score between 6 and 10, while four (67%) of the six patients with lateral injury had a GCS score <5.

All patients underwent surgery. Primary closure was performed in 7 (32%) patients, debridement of necrotic tissues and retained fragments in 15 (68%), and debridement in association with duraplasty in 6 (27%).

The result of treatment is summarised in table 1. Nine (41%) patients died despite all treatment modalities, four (44%) of whom had anteroposterior injury and five (56%) lateral. All of the patients with GCS score <5 on arrival in both groups died. In addition, one patient with anteroposterior injury and GCS score of 7, and one patient with lateral injury and GCS score of 6 died at the end of the first week post-surgery. Diffuse brain damage was the cause of death for seven (78%) of nine patients. The mortality rate was 25% among the patients with anteroposterior injury and 83% for those with lateral injury.

Mean duration of stay in the hospital was 17 days (range 1–76 days); 23 days for the patients with anteroposterior injury and 7 days for those with lateral injury.

DISCUSSION

Of all types of missile wounds to the head, PCGW are the most likely to be fatal. Usually they are caused by high

Abbreviations: CNS, central nervous system; CT, computed tomography; GCS, Glasgow Coma Score; PCGW, penetrating craniocerebral gunshot wound

Cranial gunshot wounds frequently produce devastating injuries to the central nervous system (CNS) structures.1–3 Such wounds are classified as tangential, perforating, and penetrating. Penetrating craniocerebral gunshot wounds (PCGW) are the most devastating type of missile injury to the head. This type of injury, especially if it crosses in the coronal and midline sagittal planes, is usually fatal.4

We present 22 cases of PCGW who were treated in our hospital. Depending on the intracranial course of the wounding agent, we classified the injury types in the axial plane as anteroposterior or lateral. We present a comparison of the clinical outcomes of the two groups and review of the literature.
velocity missiles or by handguns fired from a very close range, as in suicide attempts. In the military context, gunshot wounds to the head are characterized by high velocity insults, resulting in a penetrating wound. After the bullet penetrates the outer and inner tables of the skull, it crosses whole brain structures and a percussion wave is transmitted throughout the brain, causing widespread destruction of neuronal cell membranes. Varying degrees of cavitation in the brain occur along the bullet’s path, usually several times larger than the diameter of the bullet. In our series, a bullet was the wounding agent in 50% of the patients with anteroposterior and 67% of the patients with lateral injury.

The operative approach was largely the same in both groups—that is, radical debridement. Treatment comprised of four stages; immediate saving of life, prevention of infection, preservation of the nervous tissue, and restoration of anatomical structures. Although there are several different techniques for the surgical management of such injuries, this approach became the de facto standard of treatment for PGGW in our institution.

Consensus is lacking on the prognostic values and limits of salvage of PGGW in the literature. Erdogan et al reported that the presence of diffuse brain damage, brain stem injury, CNS infection, or ventricular injury was associated with poor outcome. The level of consciousness is also a reliable indicator of severity of injury, correlating predictably with morbidity and mortality. The mortality rate increases when the GCS score is <4. In our series, the GCS score was <5 in the majority of patients with lateral injury, whereas it was 6–10 in most cases of anteroposterior injury. All the patients in both groups with GCS score <5 died, which showed that the trajectory of the wounding agent does not affect the prognosis independently of the GCS score on arrival. However, the patients with later injury usually had lower GCS scores at admission.

Ventricular injury is another poor prognostic factor among these patients. The ventricular system is one of the most vulnerable brain sites to damage caused during lateral PGGW. The fragile structure of this system and close proximity to vital structures make it a vital site. It is difficult to cause a lateral injury without damaging the ventricular system, and therefore high mortality and morbidity rates are inevitable in patients with such injuries. In our series, five of the six patients with lateral injury had ventricular injury with different penetration sites.

The involvement of both cerebral hemispheres was another cause of the poor prognosis in the lateral injury group, whereas only one hemisphere was affected in the anteroposterior injury group, thus the mortality rate was lower. The protection of the other cerebral hemisphere contributed significantly to the prediction of the outcome in patients with anteroposterior injury. This group was also associated with longer hospital stay because of less brain damage compared with the lateral injury group, and required more rehabilitation period.

We observed bihemispheric damage in the patients’ brains after lateral PGGW. This rapid destruction of both hemispheres may be relevant to the high mortality rate and shorter hospital stay.

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### REFERENCES

### Table 1 Distribution of the patients according to GCS scores and type of injury, and results of treatment

<table>
<thead>
<tr>
<th>Type of injury</th>
<th>GCS score on admission</th>
<th>Result of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3–5</td>
<td>6–10</td>
</tr>
<tr>
<td>Anteroposterior</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Lateral</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
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GCS, Glasgow Coma Scale.
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