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**Regarding "Emergency Department Visits
for Chronic Subdural Hematomas within 30
Days after Surgical Evacuation with and
without Middle Meningeal Artery
Embolization"**

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Regarding “Emergency Department Visits for Chronic Subdural Hematomas within 30 Days after Surgical Evacuation with and without Middle Meningeal Artery Embolization”

I read with great interest the retrospective clinical study by Catapano et al¹ on the evaluation of emergency department (ED) visits and re-admission within 30 days for patients with chronic subdural hematomas (cSDH) with and without adjunctive middle meningeal artery embolization. To address this issue, the aforementioned authors included 137 patients with cSDH based on the inclusion criteria. Patients were divided into 2 groups (the surgery-only group and the combined group) according to the presence or absence of middle meningeal artery embolization. The authors compared the ED visits and re-admission within 30 days for patients with cSDH between the 2 groups. The results concluded that there were fewer 30-day emergency department visits in the combined group compared with the surgery-only group.

I would like to understand more information about this excellent research work and would like to share my personal views according to previously published studies.

First, the authors did not disclose the preoperative and postoperative management of patients between the 2 groups, including anticoagulants or antiplatelet agent therapy and statin use. Statins may reduce inflammatory signaling and promote hematoma resorption by decreasing the expression of inflammatory mediators on the hematoma pseudomembrane in patients with cSDH. A prospective clinical trial on critical independent predictors of the success of atorvastatin monotherapy treatment suggested that higher total cholesterol, lower hematoma volume, and less midline shift in atorvastatin monotherapy are independent factors predictive of success.² Therefore, the authors should uncover the details of postoperative management between the 2 groups.

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Second, the authors described ED visits and re-admission within 30 days as the primary outcomes. There were 34 patients with ED visits and 17 patients with re-admission within 30 days. I wonder whether follow-up recurrence of cSDH occurred in these patients and if these patients had been re-admitted to the hospital for any other reasons, which may be a potential source of bias.

In addition, the authors acknowledge the limitations of this study, including the single-center and retrospective design and all the procedures performed by the different operators and different surgical teams. Given that limitations are inevitable, even in high-quality studies, further large-scale prospective randomized controlled studies are required to validate the conclusions from this article. There are related clinical trials underway to make the current picture clearer.

Disclosure forms provided by the authors are available with the full text and PDF of this article at www.ajnr.org.

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