Fatal head injury from boxing: a case report from Greece

C Constantoyannis, M Partheni

The scans of his head showed a small left subdural haematoma, a hemorrhagic oedema with midline shift to the right, and subarachnoid haemorrhage (fig 1). A neurosurgical resident and a senior neurosurgeon were present in the emergency department (this is common practice in our service).

We used additional measures to control intracranial hypertension (200 mg mannitol rapidly administered intravenously; hyperventilation with P\text{CO}_2 27 mm Hg). His blood pressure remained >90 mm Hg throughout. We planned to perform a second computed tomographic scan when the patient was stable. However, he had a cardiac arrest 10 minutes after the previous episode. Resuscitation failed and finally he died.

DISCUSSION

The mechanism of injury to the brain during boxing is complex because it depends on both the effect of the direct impact of the gloved fist on the skull and the motion of the brain and skull in response to it. It is believed by Mawdsley and Ferguson\textsuperscript{7} that, at the time of the impact of the fist on the skull, there is a transient acceleration of the head. The skull moves faster than the brain because of the inertia of the latter, and, as the skull comes to rest, the brain continues to move. As a result, the brain impacts on bony ridges of the skull surface or on the edge of the dural attachment. Contusions and intraparenchymal haemorrhages may occur by this mechanism. These impact forces are said to be responsible for the symptoms and findings that neurosurgeons and neurologists call concussion. Stretching forces on the veins that cross the subdural space (bridging veins) result in the development of subdural haematoma, which is responsible for most deaths from boxing. Govons\textsuperscript{8} believes that an impact to the brain may damage the reticular activating system resulting in a decrease in consciousness.

Jordan and Campbell\textsuperscript{9} showed that the proportion of cerebral injuries in professional boxing is higher than in amateur boxing. In a prospective five month study of amateur boxers in Ireland, Porter and O’Brien\textsuperscript{10} noted only 33 acute mild head injuries in 281 partial or complete bouts. However, there is a good evidence that repeated brain injury, even though each individual injury produces minimal or unobservable immediate effects, causes chronic brain damage and encephalopathy.\textsuperscript{11–14}

It seems that acute subdural haematoma with underlying brain oedema has the highest mortality (60–90%).\textsuperscript{15} In our case, the cause of death seems to have been the loss of cerebral vascular autoregulation leading to hyperaemia and malignant cerebral oedema.\textsuperscript{16} 17

The Association Internationale de Boxe Amateur (AIBA), which regulates all organised and amateur boxing, has added stipulations and rules in an attempt to promote safety, such as limitation of the number of rounds, compulsory wearing of...
safety head guards, and better medical control over boxers during the match.

However, the purpose of boxing is to render the opponent unconscious, producing temporary (or, rarely, permanent) brain damage. The risks of acute and chronic injury in boxing should be explained to the athletes and their families by doctors experienced in working with boxers. We emphasise that it is important that a person’s choice should not only be free but also informed.

Young athletes may gradually be persuaded to turn their back on the sport. Despite the increasing number of ethical questions and the evidence on genetic predisposition to chronic traumatic encephalopathy in boxers, the question from neurologists and neurosurgeons remains: no more boxers or no more boxing related consequences? 14 15

In our case, there were no disputes or claims from the relatives. 16 The main purpose of this report is not to add to the rhetoric about safety and head injuries in boxing or to add to the ideological bias against boxing. Our concern is only about health.

Authors’ affiliations
C Constantoyannis, P Meni, Patras School of Medicine, Patras, Greece

Correspondence to: Dr Constantoyannis, Patras School of Medicine, Patras, Greece; constantoyannis@yahoo.com

Accepted 11 February 2003

REFERENCES

Figure 1 Computed tomographic scan showing a left small subdural haematoma, brain oedema with midline shift to the right, and subarachnoid haemorrhage.