Head injury is the most common cranial condition that neurosurgeon deal with. It is likely to remain primarily under purview for the foreseeable future *(Narayan, 1995).*

Injuries are the leading cause of death in children , and brain injury is the most common cause of pediatric traumatic death. The cerebrovascular response of the child is different from adult's in severe head injury as the patient's resting cerebral blood flow is higher. There seems to be a higher incidence of cerebral swelling. Special attention should focus on the small systemic blood volume, temperature instability and difficulty in intubating small children . The occurrence of increased intra cranial pressure in severe head injury may be as high as 60% during the patient's course *(Ward, 1995).*

Head injuries in the pediatric age group (Less than or up to 16 or 18 years) have many features that distinguish them from injuries in the adult age group. While head trauma is common among infants, children and adolescents, most injuries are minor, and few are complicated by intracranial haemorrhage *(Aronyk, 1994).*

While head injuries could be classified in several different ways, the most practical categorizations are based on mechanism , severity and morphology. As regard the mechanism , head injury could be classified into closed head injury which is either

of high velocity as (road accidents) or low velocity as falls and assault and penetrating head injury.

According to the severity, head injury could be graded into mild head injury with Glasgow coma scale (G.C.S.) 13-15. moderate head injury with Glasgow Coma scale (G.C.S) 9-12. and severe head injury with Glasgow Coma Scale (G.C.S) 8 or less .

Morphologically head injury can be classified into two main types skull fractures and intracranial lesions *(Naryan., 1995).*

The initial mangement of head injury includes proper history taking, cardiopulmonary stabilization, general examination , emergency measures for associated injuries as (tracheostomy, chest tubes, neck stabilization and abdominal paracentesis), proper neurologic examination, therapeutic agents and investigations.

C.T. scanning is clearly the procedure of choice in the evaluation of the head injured patient and has probably significantly improved the outcome of management after head injury *(Westerk, et al., 1989).*

Management of closed head injury may be either surgical interference dealing with the pathology exist or conservative management. Most epidural , subdural or intracranial haematamas associated with midline shift of 5m.m. or more are

surgically evacuated. The management of brain contusions is some what less clear-cut. Galbraith and Teasdale in their series of 26 patients with acute traumatic intracranial haematomas who were managed with surgery , found that all patients with I.C.P. greater than 30c.m.m. Hg. eventually deteriorated and required surgery. *(Gallraiths, Teasdale., 1981).*

It has been demonstrated conclusively that patients with a large (over 30 m.m) temporal lobe haematoma have a much greater risk of developing tentorial herniation than those with a frontal or parieto occipital lesion ***(Andrews B.T., et al., 1988).***

The intensive care approach to severe head injury has been associated with a drop in reported mortality figures in USA from approximately 50% in the 1970s to 36% in 1990s in the national traumatic coma data bank. The primary aim of these intensive care protocols has been to prevent secondary damage to an already injured brain ***(Marshall L.F. et al., 1991).***

The Glasgow outcome scale (G.O.S) has been widely accepted as a standard means of descrbing outcome in head injuried patients which is either favourable or unfavourable outcome. Favourable outcome include good recovery (G) and moderate disability (M.D.) while unfavourable outcome include severely disabled (S.D.), vegetative (V) and Dead (D) ***(Choi, et al., 1991).***