We report the case of a 57-day-old male infant, 2nd child of a young mother, the result of a monitored and uneventful pregnancy. Regarding the neonatal period, we point out a eutocic delivery at 39 weeks with rupture of membranes <12 hours, appropriate somatometry to gestational age, and the presence of a cephalohematoma on the left since the first day of life. The infant was brought to the emergency department due to 72 hours of partial food refusal without other complaints. A hard consistency cranial swelling, with a 5 cm diameter and limited by suture lines, was noted in the left parietal region. The evolution of the cephalic perimeter and neurological examination were normal. Skull radiography revealed, “probable epicranial cephalohematoma, partially calcified, in the parietal region, without images suggesting fracture or depression of the inner skull layer, compatible with a type 1 cephalohematoma”. Urinalysis suggested a urinary tract infection, and the patient was hospitalized to administer intravenous antibiotics. In order to reassess swelling progression and exclude possible aesthetic and neurological repercussions, an appointment was scheduled for 2 months later. Cephalohematomas correspond to subperiosteal hematic collections delimited by cranial sutures, usually with parietal location, and represent the most frequent head injury in the neonatal period, affecting between 1.5% and 2.5% of newborns.[6] They are usually noticed within the first 24-72 hours after birth and, in most cases, are reabsorbed during the first month of life.[1,4] However, calcification may occur in a small percentage of cases and then follow one of two possible pathways: resorption, usually up to 6 months, or progression to ossification. Calcification commonly begins as a ridge around the edge, subsequently growing subperiosteally towards the central region of the hematoma.[3] Ossified cephalohematomas (OC) can be classified as type 1 or 2. Type 1 OC, as described, is associated with a low risk of complications. A pseudo-cystic swelling of the diploe may be seen in cranial radiography. In type 2 OC, there is a depression of the internal band compressing the underlying space.[1,3] In the presence of a type 1 OC, due to its benignity, it is recommended to adopt a conservative attitude, monitoring focal neurological signs, changes in psychomotor development and signs of infection.[2,6] Considering their low incidence, progression and possible long-term complications are not well-known.[3] In most cases, there are only aesthetic implications, with no reported cases of neurological complications.

With the described case, the authors intend to emphasize the importance of appropriately recognizing ossified cephalohematomas, especially type 2, for early guidance and attentive monitoring.
surveillance of possible neurological consequences.

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**Conflict of interest**
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**References**


