Aneurysmal subarachnoid hemorrhage treatment

The idea of unruptured intracranial aneurysm screenings is interesting because, despite recent advances in surgical and endovascular treatment, the mortality related to aneurysmal subarachnoid hemorrhage reaches 30%.

In general, surgically managed patients include those with parenchymal hematoma and large aneurysm, while endovascular therapy is preferred in elderly, patients with significant co-morbidity, poor grades and basilar artery aneurysm.

Intravascular volume and electrolyte status should dictate type and quantity of fluids, with a goal to maintain euvolemia and normal electrolyte function.

In aneurysmal subarachnoid haemorrhage, endovascular or surgical exclusion of the aneurysm responsible for the bleeding is mandatory to prevent re-bleeding.

The recent guidelines on management of aneurysmal subarachnoid hemorrhage (aSAH) advise pharmacological thromboprophylaxis (PTP) after aneurysm obliteration.

The initiation of PTP within 24 hours may be safe after the treatment of a ruptured aneurysm or in angiogram-negative SAH patients with diffuse aneurysmal hemorrhage pattern. We suggest caution with concomitant use of PTP and dual antiplatelet agents, because it possibly increases the risk for intracerebral hemorrhage.

see Aneurysmal subarachnoid hemorrhage medical treatment.

Racial and socioeconomic factors are associated with delayed time to treatment in aSAH. Identification of factors underlying these delays and standardization of care may allow for more uniform treatment protocols and improved patient care.

Aneurysm occlusion can be performed in day time within 72 h after ictus, instead of on an emergency basis. However, due to the retrospective, non-randomized design of the study of Oudshoorn et al., the results cannot be considered as definitive evidence.

