

Cerebellar infarction treatment

Swollen cerebral and [cerebellar infarctions](#) are critical conditions that warrant immediate, specialized neurointensive care and often neurosurgical intervention.

Cerebellar infarcts are treated largely like other ischemic cerebrovascular accidents. Patients with acute events having a clear time of onset within 4.5 hours may be candidates for thrombolysis with recombinant tissue plasminogen activator (rtPA). However, given the difficulty of diagnosing posterior infarcts, this is often not possible. As with other strokes, thrombectomy can be an option. Since structures in the posterior circulation may have greater white matter content[9] and collateral flow, they are thought to have a stronger tolerance to ischemia and hypoxia than those in the forebrain. Especially in larger basilar artery occlusion, thrombectomy is often considered outside of the usual 6 hour time window, and posterior infarcts are considered amenable to even delayed reperfusion therapy.[10] Brain imaging showing a large difference or “mismatch” between the volume of brain infarcted and the area of decreased perfusion or a high degree of collateral circulation may prompt more emergent thrombectomy. When reperfusion is not an option, aspirin therapy and possibly another antiplatelet agent such as clopidogrel are indicated, with the possible addition of anticoagulation therapy in patients with embolic events. Reactive cerebral edema typically worsens over 3 to 4 days after the initial infarct and if causing worsening neurological symptoms, mandates admission to a neurologic intensive care setting for monitoring. Underlying preventable causes of the infarct are usually investigated during admission. Cardiac monitoring can demonstrate atrial fibrillation or other arrhythmias, echocardiography can reveal a patent foramen ovale or ventricular dysfunction, and blood testing can reveal diabetes mellitus or hyperlipidemia.

Cerebellar strokes after day one develop progressive edema and subsequent herniation. So, it is very important to admit these patients to ICU and monitor them very closely. The earliest symptoms are severe headache, altered mental status, vomiting, and drowsiness. Large strokes with significant cerebral edema, especially if the intracranial pressure is elevated, often require extraventricular drains, ventriculostomy, or decompressive sub-occipital craniotomy. Neurosurgical removal of infarcted tissue or hematoma is also occasionally necessary. In these cases, rapidly reversible agents such as intravenous heparin should be used. In the acute setting, mannitol, hypertonic saline, or hyperventilation can also be helpful to temporarily reduce intracranial pressure ¹⁾.

Cerebellar infarction Surgery

see [Cerebellar infarction Surgery](#).

¹⁾

Ioannides K, Tadi P, Naqvi IA. Cerebellar Infarct. 2021 Jul 8. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. PMID: 29261863.

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