Cerebral Hemorrhage

Overview

- Treat it like ACLS. Medical management must be meticulous to avoid complications.
- Complications:
  - First 3 days → herniation
  - Days 3 to 11 → Delayed Cerebral Ischemia (DCI)

GOALS

- **Neuro-exam→** know your baseline exam. Compare status changes with your baseline exam, especially somnolence.

Normotensive

- Keep SBP under 140 (or MAP under 100 depending on facility policies).
- Use arterial line for accurate measurements.
- Prn regimen → combination labetalol/hydralazine.

Normonatremia

- Keep Na between 140-145.
- Q6h Na checks.

Euvolemia

- Strict ins/outs
- Strict matching → Keep net fluid status close to zero using fluid restrictions and/or IV fluids. Avoid hypotonic oral agents (Gatorade preferred over water).

Neuro-status

- Seizure prophylaxis → Keppra
- Neuro checks
  - Q1 hours.
  - Avoid all sedating medications → interferes with neuro checks. Headaches are expected.
  - Ok to use Tylenol & lidocaine patch at back of neck. Maybe gabapentin and tramadol if truly refractive. No NSAIDs.
  - Nausea/vomiting → Zofran. Phenergan is sedating.

Aneurysmal SAH

- There is not much evidence-based medicine in cerebral hemorrhage care. Except for SAH resulting from aneurysms.
- These patients may benefit from vasospasm monitoring and control with agents like nimodipine.

Garg's Simple Medicine

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