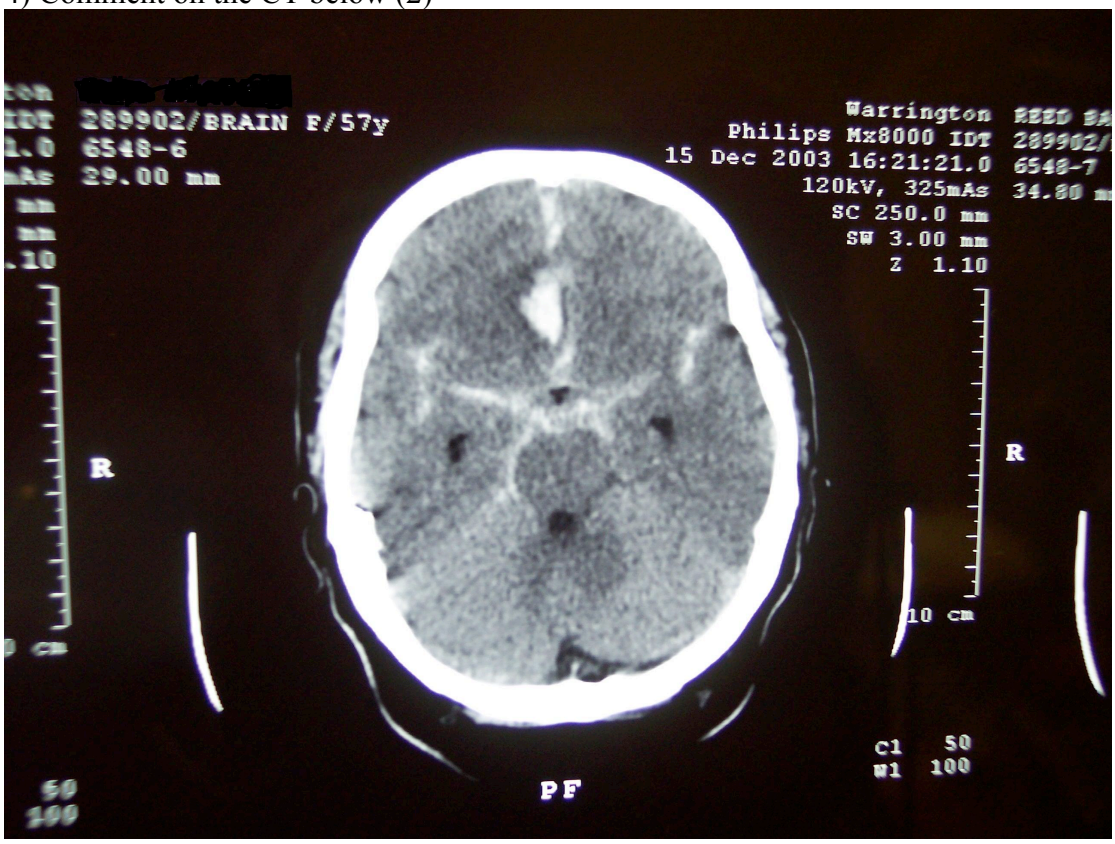
A 45 year old male is brought into the ED with a sudden onset of occipital headache, the worst he has ever had followed by collapse. He has a GCS of 7/15 with decerbrate posturing. He is hypertensive and his pulse is 78/min. The SHO says he thinks it is a Subarachnoid haemorrhage and has called the anaesthetist. When you arrive he is intubated, invasively monitored and on his way to CT.

1) How sensitive is CT in the first 12 hours after headache? (1)
98% within 12 hours
93% up to 24 hours
80% at 72 hours
50% at 1 week

2) What is the commonest cause of SAH? (1)
Ruptured berry aneurysm-77% of spontaneous SAH

3) Outline 4 features from the history would you be interesting in finding out? (2)
Smoking -strong link
Alcohol -strong link
History of hypertension -increased risk of aneurysm formation
Family History of SAH, marfans, ehlers-danlos
Prodrome or warning bleed -30-50% of aneurismal SAHs

4) Comment on the CT below (2)



Widespread fresh subarachnoid blood
Right Anterior communicating/anterior cerebral artery haematoma or right frontal intracerebral bleed.

4) What grade Hunt and Hess classification is he? (1)

Grade 5
Hunt and Hess grading system

- *Grade 1 - Asymptomatic or mild headache*
- *Grade 2 - Moderate-to-severe headache, nuchal rigidity, and no neurological deficit other than possible cranial nerve palsy*
- *Grade 3 - Mild alteration in mental status (confusion, lethargy), mild focal neurological deficit*
- *Grade 4 - Stupor and/or hemiparesis*
- *Grade 5 - Comatose and/or decerebrate rigidity*

5) Once back in resus you are asked by the anaesthetist what we should do next. What is your next therapeutic intervention and why? (1)

Nimodipine PO/NG 60mg 4 hourly or 1mg/hr IV. Helps prevent vasospasm

6) Give 2 other Complications of SAH. (2)

Seizures *Hydrocephalus* *Hyponatraemia* *Rebleeding*