Subarachnoid hemorrhage/PGS

Bleeding occurs when an **aneurysm** ruptures, most often in the area of the circle of Willis, especially on the anterior or posterior communicating artery, often when blood pressure increases (physical exertion, coitus, irritation, defecation, etc.)

The headache comes on within seconds and can be very intense. It is localized bilaterally, sometimes with a maximum occipitally. Initially, there may be a brief disturbance of consciousness. The pain is also accompanied by nausea, vomiting, photophobia and phonophobia. Meningeal syndrome continues to develop within minutes to hours. Patients are often disoriented, confused, some patients are somnolent to the point of sopor, sometimes, on the contrary, psychomotor restlessness, aggressiveness, and negativism may dominate. **Focal symptoms develop during intracerebral propagation of SAK. We assess the patient's condition using the scale according to Hunt and Hess - see cerebrovascular disease.** We establish the diagnosis with a CT scan. In about 5% of cases, the CT scan does not show SAH in the first 24 hours, so if the suspicion of SAH persists, we indicate an examination of the cerebrospinal fluid. A typical cerebrospinal fluid finding is the finding of oxyhemoglobin during spectrophotometric examination. If SAH is proven, we send the patient to neurosurgery for cerebral panangiography, which should be performed within 72 hours of the onset of symptoms due to the risk of vasospasm. If an aneurysm is found and the H+H score is up to 3, surgery is indicated - either clipping the aneurysm neck or filling the aneurysm cavity with a detachable coil - coiling. If an aneurysm is not detected, the patient is treated conservatively - painkillers, mucolytics and laxatives, and after 3-6 weeks a control panangiography is indicated.