

Intracerebral hemorrhage treatment

- [Clinical Management of Cerebral Amyloid Angiopathy](#)
- [Japanese Nationwide Questionnaire Survey on the Treatment and Management of Subarachnoid Hemorrhage Due to Ruptured Cerebral Aneurysm](#)
- [Regional Differences in Presentation, Cause, and Outcome of Reversible Cerebral Vasoconstriction Syndrome](#)
- [Postacute Discharge Destination and Major Adverse Cardiovascular Events Among Patients With Intracerebral Hemorrhage](#)
- [Tranexamic Acid Ameliorated Bleeding Tendency in Abdominal Aortic Aneurysm-Induced Chronic Disseminated Intravascular Coagulation](#)
- [Rapid Diagnosis of Intracerebral Hemorrhage in Patients With Acute Stroke by Measuring Prehospital GFAP Levels on a Point-of-Care Device \(DETECT\)](#)
- [Collaboration on the optimal timing of anticoagulation after ischaemic stroke and atrial fibrillation: a systematic review and prospective individual participant data meta-analysis of randomised controlled trials \(CATALYST\)](#)
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GCS, systolic blood pressure, intraventricular hemorrhage, bleeding volume, and past blood pressure control are the main factors affecting the critical care needs of patients with ICH. ¹⁾

Based on the [MIMIC-III database](#), Yi et al. firstly described the dissimilarities in survival probability, mortality, and neurological recovery among mainstream treatments for intracerebral hemorrhage; secondly, patient classification was determined by important clinical features; and outcome variations among treatment groups were compared. The 28-day, 90-day, and in-hospital mortality in the craniotomy group were significantly lower than minimally invasive surgery (MIS) and non-surgical group patients; and, the medium/long-term mortality in the MIS group was significantly lower than the non-surgical group. The craniotomy group positively correlated with short-term GCS recovery compared with the MIS group; no difference existed between the non-surgical and MIS groups. The craniotomy group's 90-day survival probability and short-term GCS recovery were superior to the other two treatments in the subgroups of first GCS 3-12; this tendency also presented in the MIS group over the non-surgical group. For milder patients (first GCS > 12), the three treatment regimens had a minimal effect on patient survival, but the non-surgical group showed an advantage in short-term GCS recovery. Craniotomy patients have lower mortality and a better short-term neurological recovery in an ICH population, especially in short-to-medium term mortality and short-term neurological recovery over MIS patients. In addition, surgical treatment is recommendable for patients with a GCS ≤ 12. ²⁾

Anticoagulation reversal, intensive blood pressure lowering, neurosurgery and access to critical care might all be beneficial in acute intracerebral hemorrhage (ICH) ³⁾.

Spontaneous intracerebral hemorrhage treatment

see [Spontaneous intracerebral hemorrhage treatment](#).

Traumatic intracerebral hemorrhage treatment

see [Traumatic intracerebral hemorrhage treatment](#).

1)

Wu C, Pan X, Xu L, Lu Z, Wang Z, Xu L, Xu Y. Development of a risk prediction model for critical care needs in patients with intracerebral hemorrhage: a retrospective cohort. BMC Nurs. 2024 Oct 19;23(1):770. doi: 10.1186/s12912-024-02319-8. PMID: 39427213.

2)

Yi Y, Che W, Cao Y, Chen F, Liao J, Wang X, Lyu J. Prognostic [data analysis](#) of [surgical treatments](#) for [intracerebral hemorrhage](#). Neurosurg Rev. 2022 Apr 19. doi: 10.1007/s10143-022-01785-5. Epub ahead of print. PMID: 35441246.

3)

Parry-Jones AR, Sammut-Powell C, Paroutoglou K, Birleson E, Rowland J, Lee S, Cecchini L, Massyn M, Emsley R, Bray B, Patel H. An intracerebral hemorrhage care bundle is associated with lower case-fatality. Ann Neurol. 2019 Jul 10. doi: 10.1002/ana.25546. [Epub ahead of print] PubMed PMID: 31291031.

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