



BILATERAL CEREBELLAR HEMORRHAGE: A RARE PRESENTATION

General Medicine

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ABSTRACT

Hypertensive intracranial hemorrhages (ICH) are for the most part singular, however event of concurrent numerous ICH due to hypertension is very uncommon. They are normally the consequence of uncontrolled hypertension and unpredictable medication consumption and are related with cerebral aneurysms, vascular abnormalities, hemorrhagic dead tissue, coagulation deserts, cerebral angiitis and sinus apoplexy. We present an instance of a 70-year-old hypertensive male on sporadic treatment who introduced to the setback in an oblivious state with a circulatory strain of 180/120 mm of Hg, profoundly incapacitated and with two-sided non-responding enlarged understudies. The patient had five scenes of shot retching with serious cerebral pain a day prior to confirmation. She was likewise a known instance of profound venous apoplexy and was on warfarin for the equivalent. On confirmation, her modernized tomography examination uncovered reciprocal lobar cerebellar discharge with obstructive hydrocephalus and diffuse cerebral edema, which is a rare. Concurrent various ICH in the cerebellum because of hypertension are uncommon and related with high bleakness and mortality. So it is significant for clinical experts to start legitimate treatment or possibly allude such patients to claim to fame focuses immediately.

KEYWORDS

Cerebellar stroke, Hypertension, Intracranial hemorrhages

INTRODUCTION

Hypertensive intracranial hemorrhage (ICH) is for the most part alone and situated in characterized locales with a generally common example of expansion. ICH event accounts for roughly 20 to 35% of all strokes in Asia. 1-3 The event of concurrent various ICHs (SMICHs) is an uncommon clinical substance, with a predominance pace of 1-4.7% of all unconstrained ICH. 4-7 SMICHs are related with cerebral aneurysms, vascular distortions, hemorrhagic dead tissue, coagulation deserts, cerebral angiitis, sinus apoplexy, as well as amyloid angiopathy. Here, we present an instance of a 70-year-old hypertensive patient with two-sided cerebellar hemorrhages which is an extraordinariness.

CASE REPORT

A 70-year-old male patient presented to the casualty in an unconscious state. He had a blood pressure of 180/120 mm of Hg, pulse rate of 60 beats/min. Her neurological status on admission was deeply comatose and was afebrile with bilateral non-reacting dilated pupils. On enquiry, it was found that the patient was a known hypertensive since last 15 years but on irregular medications for the same. Her relatives reported that a day before she had five episodes of projectile vomiting, non-bilious and containing food particles associated with severe headache which was throbbing and continuous for which she visited a local practitioner who prescribed her a few medications. Patient felt comfortable after the medications and was off to sleep. But the next morning she was unresponsive and unconscious after which she was referred to us for further management. Her computerized tomography scan revealed bilateral lobar cerebellar hemorrhage with obstructive hydrocephalus and diffuse cerebral edema.

DISCUSSION

Recurrent ICH in hypertensive patients is certainly not an abnormal finding yet the concurrent event of at least two ICH is an uncommon clinical entity. [9-11] The event of recurrent ICHs is an uncommon clinical element, with a pervasiveness 1-4.7% of all unconstrained ICH. [4-7] Several danger factors including blood pressure, glucose, cigarette smoking, liquor drinking and hypercholesterolemia have been confirmed as accelerating factors for hypertensive ICH. Nonetheless, the predominance of hypercholesterolemia was significantly higher in the gathering with different ICHs [8]. Different ICH are seldom connected with cerebral amyloid angiopathy, venous sinus apoplexy, oral anticoagulant treatment, vasculitis, hemorrhagic change of cerebral infarcts and within the sight of different intracranial pathologies, for example, vascular peculiarities or tumors. [12] Kabuto et al. Announced that the most widely recognized area of different ICHs was the two-sided putamen, while just two of [17] different ICH patients for his situation arrangement had putaminal furthermore, cerebellar hemorrhages. [8,13] The synchronous advancement of ICH in two unique blood vessel regions may happen in hypertensive

patients and make ICH. [14] The current hypothesis is that the underlying causes coming about underlying or hemodynamic changes that will in general bring about a quick second hemorrhage. [3,15] The underlying drain that outcomes from a burst microaneurysm may cause the vital conditions, for example, hemodynamic changes and underlying twisting, that break other miniature aneurysms, vessels, or potentially venules on the contralateral side, which are at danger in a generally short time. [13] Our patient likewise had respective cerebellar which have distinctive vascular regions, as is an uncommon element. Such cases have high paces of dreariness and mortality. Most of patients with ICH have helpless results on account of their poor neurological status, late introduction and seriously impeded consciousness. The death rate for patients with recurrent ICH is a lot higher than that of patients with a solitary ICH, regardless of whether the hematomas are small. [13-15] The signs for medical procedure if there should arise an occurrence of various concurrent hypertensive ICHs are ambivalent. [6] For patients with various ICHs, medical procedure appears of minor use. [3] Treatment might be by the same token clinical or careful, and the choice for treatment ought to be founded on the Glasgow Coma score of the patient, the areas and sizes of the hematomas, and the presence of extra clinical issues. Regardless, the high mortality furthermore, horribleness rates in these patients make the treatment of a particularly decimating condition difficult. Subsequently, preventive measures should be taken. [8] The most well-known side effects of cerebellar drain are energy, extreme sickness, retching and ataxia. Migraine might be serious. Patients with cerebellar drain can quickly become sluggish inside the space of hours after the beginning. Adjustment of mental status can be auxiliary to harm to the pons or midbrain or unexpected obstructive hydrocephalus. Sporadically, fringe facial shortcoming and flat look hindrance can likewise happen, addressing herniation onto the pons. These cases have a helpless visualization.

REFERENCES

- Kojima S, Omura T, Wakamatsu W, Kishi M, Yamazaki T, Iida M, et al. Prognosis and disability of stroke patients after 5 years in Akita, Japan. *Stroke* 1990;21:72-7.
- Lin YT, Lo YK, Kuo HC, Chang YT, Chang MH, Li JY. Stroke registry in Kaohsiung Veterans General Hospital. *Zhonghua Yi Xue Za Zhi (Taipei)* 2002;65:307-13.
- Yen CP, Lin CL, Kwan AL, Lieu AS, Hwang SL, Lin CN, et al. Simultaneous multiple hypertensive intracerebral haemorrhages. *Acta Neurochir (Wien)* 2005;147:393-9.
- Balasubramaniam S, Nadkarni TD, Goel A. Simultaneous thalamic and cerebellar hypertensive haemorrhages. *Neurol India* 2007;55:183-4.
- Sorimachi T, Ito Y, Morita K, Fujii Y. Microbleeds on gradient-echo T2(*)-weighted MR images from patients with multiple simultaneous intracerebral haemorrhages. *Acta Neurochir (Wien)* 2007;149:171-6.
- Takeuchi S, Takasato Y, Masako H, Hayakawa T, Yatsushige H, Sugawara T. Simultaneous multiple hypertensive intracranial hemorrhages. *J Clin Neurosci* 2011;18:1215-8.
- Weisberg L. Multiple spontaneous intracerebral hematomas: Clinical and computed tomographic correlations. *Neurology* 1981;31:897-900.
- Silliman S, McGill J, Booth R. Simultaneous bilateral hypertensive putaminal hemorrhages. *J Stroke Cerebrovasc Dis* 2003;12:44-6.
- Bae H, Jeong D, Doh J, Lee K, Yun I, Byun B. Recurrence of bleeding in patients with hypertensive intracerebral hemorrhage. *Cerebrovasc Dis* 1999;9:102-8.

10. Bamford J, Sandercock P, Dennis M, Warlow C, Jones L, McPherson K, et al. A prospective study of acute cerebrovascular disease in the community: The Oxfordshire Community Stroke Project 1981-86. 1. Methodology, demography and incident cases of first-ever stroke. *J Neurol Neurosurg Psychiatry* 1988;51:1373-80.
11. Bayramoglu M, Karatas M, Leblebici B, Cetin N, Sözüy S, Turhan N. Hemorrhagic transformation in stroke patients. *Am J Phys Med Rehabil* 2003;82:48-52.
12. Mauriño J, Saposnik G, Lepera S, Rey RC, Sica RE. Multiple simultaneous intracerebral hemorrhages: Clinical features and outcome. *Arch Neurol* 2001;58:629-32.
13. Kabuto M, Kubota T, Kobayashi H, Nakagawa T, Arai Y, Kitai R. Simultaneous bilateral hypertensive intracerebral hemorrhages – two case reports. *Neurol Med Chir (Tokyo)* 1995;35:584-6.
14. Kohshi K, Abe H, Tsuru E. Simultaneous hypertensive intracerebral hematomas: Two case reports. *J Neurol Sci* 2000;181:137-9.
15. Tanno H, Ono J, Suda S, Karasudani H, Yamakami I, Isobe K, et al. Simultaneous, multiple hypertensive intracerebral hematomas: Report of 5 cases and review of literature. *No Shinkei Geka* 1989;17:223-8.