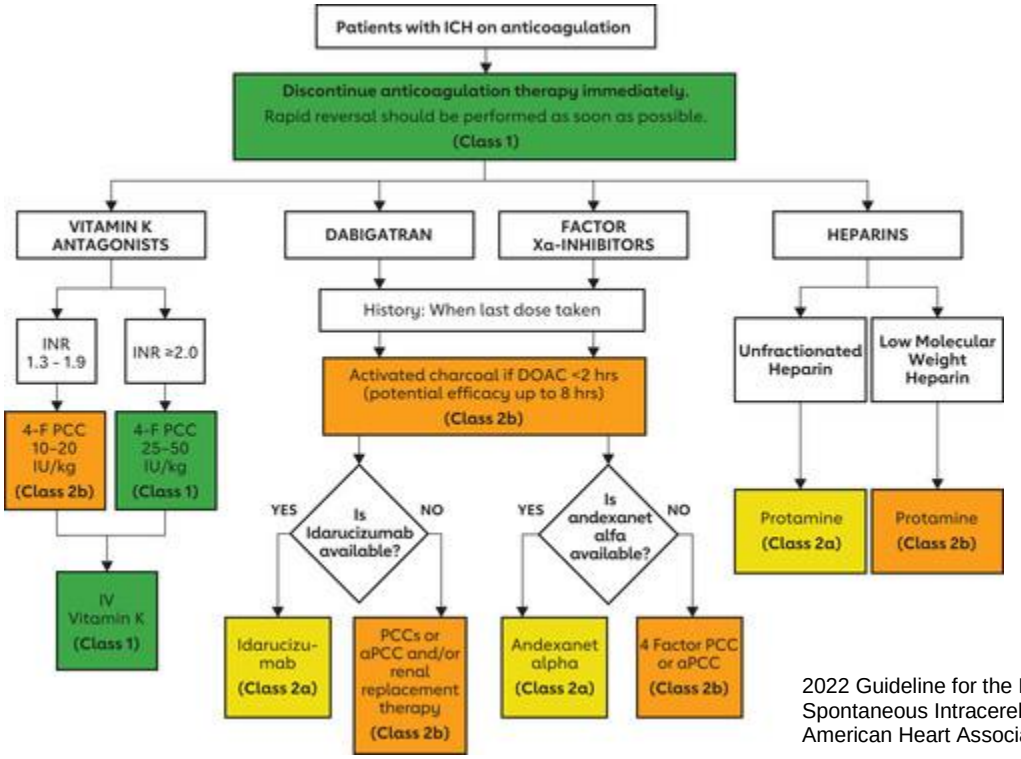
Anticoagulant-associated intracranial hemorrhage

Background

- Most hemorrhage expansion occurs in the first 6 hours and is associated with worse outcome. Hemorrhagic expansion can be prevented by controlling blood pressure and emergent reversal of anticoagulation.
- CTA head should be considered to identify patients at risk of hematoma expansion and to evaluate for underlying vascular malformations, particularly if lobar or involving brainstem or cerebellum; post contrast CT scan may identify a slowly expanding hemorrhage or underlying brain tumor.
- If patient is deteriorating, **do NOT** keep HOB flat for advanced imaging.



2022 Guideline for the Management of Patients With Spontaneous Intracerebral Hemorrhage: A Guideline From the American Heart Association/American Stroke Association

Recommendations:

- For most patients, reduce SBP to 130-140mmHg, to reduce hemorrhagic expansion and mortality; if transferred, ensure BP has reached target before sending
    - AHA Guidelines do not specify the antihypertensive to use, but IV nicardipine is the most frequently used medication in modern clinical trials; other options include labetalol (if not bradycardic), clevidipine, hydralazine (if bradycardic), enalapril
- HOB elevated to 30 degrees; do not leave HOB flat for prolonged imaging or during transfer
- Frequent neurocheck and vital signs
    - 0-6 hours from symptom detection – every 30 minutes
    - 6-24 hours from symptom detection – every 1 hour
    - >24 hours and blood pressure not at goal or worsening exam – every 1 hour
    - >24 hours and blood pressure at goal – every 4 hours, in neurologically stable patient
- Consult with neurology and/or neurosurgery for determination of neurosurgical intervention
- Document the severity of the ICH with the ICH score (refer to Spontaneous intracranial hemorrhage)
- Prophylactic antiseizure medication is not recommended
- Treatment of glucose <60mg/dL is recommended; if >180mg/dL, it is reasonable.
- Cardiac monitoring for at least 24hrs