Subarachnoid haemorrhage of unknown cause

The term subarachnoid haemorrhage indicates no more than the presence of blood in the cerebrospinal fluid on lumbar puncture; a more correct term is spontaneous intracranial haemorrhage, which distinguishes the condition from traumatic haemorrhage (a more common cause of blood-stained cerebrospinal fluid) and reminds us that intracranial haemorrhage may occur without the presence of blood in the subarachnoid space.

Faced with the classical presentation of sudden onset of severe headache, vomiting, and neck stiffness, with or without transient loss of consciousness, the physician’s task is to assess the likelihood that the cause of the haemorrhage is a remediable lesion and, therefore, the need for intracranial investigations. The choice and extent of the intracranial investigations and the consequent management of the patient are the neurosurgeon’s concern, while the later problem of prognosis is left for the physician. Among identifiable causes of subarachnoid haemorrhage are hypertension, aneurysm, angioma, and, less commonly, intracranial tumour (usually malignant), and blood dyscrasias. The prognosis depends in each case on management (which for aneurysm and angioma in turn depends largely on whether the lesion is operable), on the state of the cerebral circulation as indicated by the patient’s neurological condition, and on whether or not arterial spasm is shown by angiography.

In some patients investigations fail to identify any causal lesion for the subarachnoid haemorrhage, and until recently the prognosis in such cases has been uncertain. Incomplete follow-up of the patients and the omission of vertebral angiography in most cases have added to the uncertainties. A recent study by Hayward is therefore welcome in giving some guide to the prognosis. Of 592 patients with subarachnoid haemorrhage admitted during two years, the cause was unknown in 91; of these, 51 had bilateral carotid and vertebral angiography and also computerised tomography (CT scan), so that the presence of a causal lesion had been excluded by every known means (the CT scan has been claimed to differentiate between primary cerebral haemorrhage and aneurysmal rupture with an accuracy of 90%). The patients’ age and sex distribution was similar to that recorded in series of proved cases of intracranial aneurysm, but the incidence of arterial spasm was much lower. There is no conclusive evidence that in cases of this kind haemorrhage is due to small aneurysms that undergo thrombosis or are destroyed at the time of haemorrhage.

None of the 51 patients had a further haemorrhage during the ensuing two months—an observation of practical importance, since further haemorrhage could be expected in that time in half of all patients with a proved aneurysm. Unfortunately, only 41 of the 51 patients had further follow-up, for periods ranging from 3½ months to 2½ years; even so, no patient is known to have had a further haemorrhage as yet. Clearly it will be helpful if Hayward’s study is continued, and further efforts are made to trace all 51 patients fully investigated. Although such patients can presumably be reassured that there are negligible risks of a further haemorrhage, such a conclusion is unlikely to be acceptable for life insurance, at least on the evidence so far available.

The extent of intracranial investigations in a patient who has had a subarachnoid haemorrhage remains a matter for clinical judgment. If adverse factors such as age, hypertension, cardiovascular disease, and neurological deficit preclude active treatment for a vascular anomaly then angiography is not justified. CT scanning has proved a major advance in this and so many other disorders, and is particularly valuable in demonstrating the compressing intracranial haematoma that requires urgent evacuation whatever the nature of the causal lesion. The physician must remain aware, however, that even when CT scan appearances suggest an aneurysmal haemorrhage this should not encourage angiography (and particularly vertebral angiography with its hazards) to be performed in the face of adverse clinical factors.

Television medicine

Ask a group of doctors what they think of the television coverage of medicine and the one certainty is that they will hold strong views, for doctors, like their patients, find medical programmes compulsive viewing. Many of the documentaries are superb, but the news coverage is less consistent, and occasional programmes provoke a hostile response. This is not due to the outdated attitude that patients are happier if left in ignorance, for most doctors believe that people will take more care of their health if they understand how their bodies function and what can go wrong. Most accept, too, that patients should expect some say in the management of their diseases. The serious criticisms of television medicine concern not its content but its style. They fall into two broad categories: complaints by doctors who have taken part in programmes and allegations by doctor-viewers that programmes too often misinform.

Certainly many doctors who have been interviewed for television programmes have been angered by the final version as screened. Sometimes a 20-minute filmed discussion is cut down to a minute or two; occasionally nothing appears at all after a half-day given over to the TV team. Our special correspondent (see p 348) found that the regret was caused less by damage to the interviewed doctors’ amour propre than by their conviction that their words had been edited—often very selectively—to support the case being made by the television reporter.

For television programmes, whatever their subject matter,