Is Craniotomy for Intracerebral Hemorrhage Treated Properly in the Latest AHA Guideline?

To the Editor:

Beneficial effects of the surgical intervention, especially craniotomy, for the treatment of patients with putaminal hemorrhage, is inconclusive. In the recent issue of Stroke,1 guidelines for the treatment of spontaneous intracerebral hemorrhage were presented. Craniotomy for the supratentorial intracerebral hemorrhage was placed Class III, not beneficial, except for the superficial lobar hemorrhage.

Such a recommendation must be drawn from the results of the international STICH study,2 in which early surgical intervention yielded only marginal insignificant benefit in mortality and morbidity over initial conservative treatment. It should be noted, however, that one fourth of the initial conservative treatment group eventually had surgery within 99 hours of ictus. Initial conservative treatment policy therefore maintained just the equal levels of outcome as early surgical intervention policy, only when surgical intervention with an average time lag of 30 hours was added in a significant number of the cases.

From this point of view, placement of craniotomy for the intracerebral hemorrhage in Class III category is misguiding for the physicians treating stroke patients and also for the families of the stroke patients.

Disclosures

None.

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