AHA/ASA Guideline

Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage
A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association

The American Academy of Neurology affirms the value of this statement as an educational tool for neurologists.
Endorsed by the American Association of Neurological Surgeons and Congress of Neurological Surgeons; and by the Society of NeuroInterventional Surgery

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Purpose—The aim of this guideline is to present current and comprehensive recommendations for the diagnosis and treatment of aneurysmal subarachnoid hemorrhage (aSAH).

Methods—A formal literature search of MEDLINE (November 1, 2006, through May 1, 2010) was performed. Data were synthesized with the use of evidence tables. Writing group members met by teleconference to discuss data-derived recommendations. The American Heart Association Stroke Council’s Levels of Evidence grading algorithm was used to grade each recommendation. The guideline draft was reviewed by 7 expert peer reviewers and by the members of the Stroke Council Leadership and Manuscript Oversight Committees. It is intended that this guideline be fully updated every 3 years.

Results—Evidence-based guidelines are presented for the care of patients presenting with aSAH. The focus of the guideline was subdivided into incidence, risk factors, prevention, natural history and outcome, diagnosis, prevention of rebleeding, surgical and endovascular repair of ruptured aneurysms, systems of care, anesthetic management during repair, management of vasospasm and delayed cerebral ischemia, management of hydrocephalus, management of seizures, and management of medical complications.

Conclusions—aSAH is a serious medical condition in which outcome can be dramatically impacted by early, aggressive, expert care. The guidelines offer a framework for goal-directed treatment of the patient with aSAH. (Stroke. 2012;43:00-00.)

Key Words: AHA Scientific Statements □ aneurysm □ delayed cerebral ischemia □ diagnosis □ subarachnoid hemorrhage □ treatment □ vasospasm

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To respond to the growing call for more evidenced-based medicine, the American Heart Association (AHA) commissions guidelines on various clinical topics and endeavors to keep them as current as possible. The prior aneurysmal subarachnoid hemorrhage (aSAH) guidelines, sponsored by the AHA Stroke Council, were previously issued in 1994 and 2009. The 2009 guidelines covered literature through November 1, 2006. The present guidelines primarily cover literature published between November 1, 2006, and May 1, 2010, but the writing group has strived to place these data in the greater context of the prior publications and recommendations. In cases in which new data covered in this review have resulted in a change in a prior recommendation, this is explicitly noted.

aSAH is a significant cause of morbidity and mortality throughout the world. Although the incidence of aSAH varies widely among populations, perhaps because of genetic differences, competing burden of disease, and issues of case ascertainment, at the very least, a quarter of patients with aSAH die, and roughly half of survivors are left with some persistent neurological deficit. That said, case-fatality rates appear to be falling, and increasing data suggest that early aneurysm repair, together with aggressive management of complications such as hydrocephalus and delayed cerebral ischemia (DCI), is leading to improved functional outcomes. These improvements underscore the need to continually reassess which interventions provide the greatest benefit to patients.

Although large, multicenter, randomized trial data confirming effectiveness are usually lacking for many of the interventions discussed, the writing group did its best to summarize the strength of the existing data and make practical recommendations that clinicians will find useful in the day-to-day management of aSAH. This review does not discuss the multitude of ongoing studies. Many of these can be found at http://www.strokecenter.org/trials/. The mechanism of reviewing the literature, compiling and analyzing the data, and determining the final recommendations to be made is identical to the 2009 version of this guideline.

The members of the writing group were selected by the AHA to represent the breadth of healthcare professionals who must manage these patients. Experts in each field were screened for important conflicts of interest and then met by telephone to determine subcategories to evaluate. These subcategories included incidence, risk factors, prevention, natural history and outcome, diagnosis, prevention of rebleeding, surgical and endovascular repair of ruptured aneurysms, systems of care, anesthetic management during repair, management of vasospasm and DCI, management of hydrocephalus, management of seizures, and management of medical complications. Together, these categories were thought to encompass all of the major areas of disease management, including prevention, diagnosis, and treatment. Each subcategory was led by 1 author, with 1 or 2 additional coauthors who made contributions. Full MEDLINE searches were conducted independently by each author and coauthor of all English-language papers on treatment of relevant human disease. Drafts of summaries and recommendations were circulated to the entire writing group for feedback. A conference call was held to discuss controversial issues. Sections were revised and merged by the writing group chair. The resulting draft was sent to the entire writing group for comment. Comments were incorporated into the draft by the writing group chair and vice chair, and the entire writing group was asked to approve the final draft. The chair and vice chair revised the document in response to peer review, and the document was again sent to the entire writing group for additional suggestions and approval.

The recommendations follow the AHA Stroke Council’s methods of classifying the level of certainty of the treatment effect and the class of evidence (Tables 1 and 2). All Class I recommendations are listed in Table 3. All new or revised recommendations are listed in Table 4.

Incidence and Prevalence of aSAH

Considerable variation in the annual incidence of aSAH exists in different regions of the world. A World Health Organization study found a 10-fold variation in the age-adjusted annual incidence in countries in Europe and Asia, from 2.0 cases per 100 000 population in China to 22.5 cases per 100 000 in Finland. A later systematic review supported a high incidence of aSAH in Finland and Japan, a low incidence in South and Central America, and an intermediate incidence of 9.1 per 100 000 population in other regions. In a more recent systematic review of population-based studies, the incidence of aSAH ranged from 2 to 16 per 100 000. In that review, the pooled age-adjusted incidence rate of aSAH in low- to middle-income countries was found to be almost double that of high-income countries. Although some reports have suggested the incidence of aSAH in the United States to be 9.7 per 100 000, the 2003 Nationwide Inpatient Sample provided an annual estimate of 14.5 discharges for aSAH per 100 000 adults. Because death resulting from aSAH often occurs before hospital admission (an estimated 12% to 15% of cases), the true incidence of aSAH might be even higher. Although a number of population-based studies have indicated that the incidence of aSAH has remained relatively stable over the past 4 decades, a recent review that adjusted for age and sex suggested a slight decrease in incidence between 1950 and 2005 for regions other than Japan, South and Central America, and Finland. These data are consistent with studies that show that the incidence of aSAH increases with age, with a typical average age of onset in adults ≥50 years of age. aSAH is relatively uncommon in children; incidence rates increase as children get older, with incidence ranging from 0.18 to 2.0 per 100 000. The majority of studies also indicate a higher incidence of aSAH in women than in men. Most recent pooled figures report the incidence in women to be 1.24 (95% confidence interval, 1.09–1.42) times higher than in men. This is lower than a previous estimate of 1.6 (95% confidence interval, 1.1–2.3) for the years 1960 to 1994. Evidence of a sex-age effect on aSAH incidence has emerged from pooled study data, with a higher incidence reported in younger men (25–45 years of age), women between 55 and 85 years of age, and men >85 years of age. Differences in incidence of aSAH by race and ethnicity appear to exist.
Blacks and Hispanics have a higher incidence of aSAH than white Americans.6,24,25

**Risk Factors for and Prevention of aSAH**

Behavioral risk factors for aSAH include hypertension, smoking, alcohol abuse, and the use of sympathomimetic drugs (eg, cocaine). In addition to female sex (above), the risk of aSAH is increased by the presence of an unruptured cerebral aneurysm (particularly those that are symptomatic, larger in size, and located either on the posterior communicating artery or the vertebrobasilar system), a history of previous aSAH (with or without a residual untreated aneurysm), a history of familial aneurysms (at least 1 first-degree family member with an intracranial aneurysm, and especially if ≥2 first-degree relatives are affected) and family history of aSAH,26,27 certain genetic syndromes, such as autosomal dominant polycystic kidney disease and type IV Ehlers-Danlos syndrome.28,29 Novel findings reported since publication of the previous version of these guidelines include the following: (1) Aneurysms in the anterior circulation appear to be more prone to rupture in patients <55 years of age, whereas posterior communicating aneurysms ruptured more frequently in men, and basilar artery aneurysm rupture is associated with lack of use of alcohol.30

**Table 1. Applying Classification of Recommendation and Level of Evidence**

A recommendation with Level of Evidence B or C does not imply that the recommendation is weak. Many important clinical questions addressed in the guidelines do not lend themselves to clinical trials. Although randomized trials are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

*Data available from clinical trials or registries about the usefulness/efficacy in different subpopulations, such as sex, age, history of diabetes, history of prior myocardial infarction, history of heart failure, and prior aspirin use.*

*For comparative effectiveness recommendations (Class I and IIa, Level of Evidence A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.*
aneurysms rupture appears to be smaller in those patients with the combination of hypertension and smoking than in those with either risk factor alone.31 (3) Significant life events such as financial or legal problems within the past month may increase the risk of aSAH.32 (4) Aneurysm size greater than 7 mm has been shown to be a risk factor for rupture.33 (5) There does not appear to be an increased risk of aSAH in pregnancy, delivery, and puerperium.34,35

Inflammation appears to play an important role in the pathogenesis and growth of intracranial aneurysms.36 Prominent mediators include the nuclear factor \( \kappa \) light-chain enhancer of activated B cells (NF-\( \kappa \)B),37 tumor necrosis factor, macrophages, and reactive oxygen species. Although there are no controlled studies in humans, 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statin").38 and calcium channel blockers may retard aneurysm formation through the inhibition of NF-\( \kappa \)B and other pathways. Among the risk factors for aSAH, clearly attributable and modifiable risks are very low body mass index, smoking, and high alcohol consumption.31,39,40 Yet, despite marked improvements in the treatment of hypertension and hyperlipidemia and the decrease in rates of smoking over time, the incidence of aSAH has not changed appreciably in 30 years.16

It is possible that diet increases the risk of stroke in general and aSAH in particular. In an epidemiological study of Finnish smokers who were monitored for >13 years, increased consumption of yogurt (but not all dairy products) was associated with a higher risk of aSAH.41 Greater vegetable consumption is associated with a lower risk of stroke and aSAH.42 Higher coffee and tea consumption43 and higher magnesium consumption44 were associated with reduced risk of stroke overall but did not change the risk of aSAH.

Predicting the growth of an individual intracranial aneurysm and its potential for rupture in a given patient remains problematic. When followed up on magnetic resonance imaging, larger aneurysms (\( \geq 8 \) mm in diameter) tended to grow more over time,45 which implies a higher risk of rupture. Several characteristics of aneurysm morphology (such as a bottleneck shape46 and the ratio of size of aneurysm to parent vessel47,48) have been associated with rupture status, but how these might be applied to individual patients to predict future aneurysmal rupture is still unclear.35 Variability within each patient is unpredictable at this time, but such intraindividual variability markedly changes the risk of aneurysm detection and rupture and may attenuate the benefits of routine screening in high-risk patients.49

Given such uncertainties, younger age, longer life expectancy, and higher rate of rupture all make treatment of unruptured aneurysms more likely to be cost-effective and reduce morbidity and mortality.50 Two large observational studies of familial aneurysms suggest that screening these patients may also be cost-effective in preventing aSAH and improving quality of life.26,27 Smaller studies have suggested that screening of those with 1 first-degree relative with aSAH may be justified as well, but it is far less clear whether patients who underwent treatment for a previous aSAH require ongoing screening.51,52 In the Cerebral Aneurysm Rerupture After Treatment (CARAT) study, recurrent aSAH was predicted by incomplete obliteration of the aneurysm and occurred a median of 3 days after treatment but rarely after 1 year.5 Repeated noninvasive screening at later times may not be cost-effective, increase life expectancy, or improve quality of life in unselected patients.54 Patients with adequately obliterated aneurysms after aSAH have a low risk of recurrent aSAH for at least 5 years,55,56 although some coiled aneurysms require retreatment.57

Risk Factors for and Prevention of aSAH: Recommendations

1. Treatment of high blood pressure with antihypertensive medication is recommended to prevent ischemic stroke, intracerebral hemorrhage, and cardiac, renal, and other end-organ injury (Class I; Level of Evidence A).
2. Hypertension should be treated, and such treatment may reduce the risk of aSAH (Class I; Level of Evidence B).
3. Tobacco use and alcohol misuse should be avoided to reduce the risk of aSAH (Class I; Level of Evidence B).
4. In addition to the size and location of the aneurysm and the patient’s age and health status, it might be reasonable to consider morphological and hemodynamic characteristics of the aneurysm when discussing the risk of aneurysm rupture (**Class IIb; Level of Evidence B**). (New recommendation)

5. Consumption of a diet rich in vegetables may lower the risk of aSAH (**Class IIb; Level of Evidence B**). (New recommendation)

6. It may be reasonable to offer noninvasive screening to patients with familial (at least 1 first-degree relative) aSAH and/or a history of aSAH to evaluate
Table 4. New or Revised Recommendations

<table>
<thead>
<tr>
<th>New or Revised</th>
<th>Recommendation</th>
<th>Class of Recommendation/Level of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>1. In addition to the size and location of the aneurysm and the patient’s age and health status, it might be reasonable to consider morphological and hemodynamic characteristics of the aneurysm when discussing the risk of aneurysm rupture.</td>
<td>Class IIb, Level B</td>
</tr>
<tr>
<td>New</td>
<td>2. Consumption of a diet rich in vegetables may lower the risk of aSAH.</td>
<td>Class IIb, Level B</td>
</tr>
<tr>
<td>New</td>
<td>3. After any aneurysm repair, immediate cerebrovascular imaging is generally recommended to identify remnants or recurrence of the aneurysm that may require treatment.</td>
<td>Class I, Level B</td>
</tr>
<tr>
<td>New</td>
<td>4. After discharge, it is reasonable to refer patients with aSAH for a comprehensive evaluation, including cognitive, behavioral, and psychosocial assessments.</td>
<td>Class IIa, Level B</td>
</tr>
<tr>
<td>New</td>
<td>5. CTA may be considered in the workup of aSAH. If an aneurysm is detected by CTA, this study may help guide the decision for the type of aneurysm repair, but if CTA is inconclusive, DSA is still recommended (except possibly in the instance of classic perimesencephalic SAH).</td>
<td>Class IIb, Level C</td>
</tr>
<tr>
<td>New</td>
<td>6. Magnetic resonance imaging (fluid-attenuated inversion recovery, proton density, diffusion-weighted imaging, and gradient echo sequences) may be reasonable for the diagnosis of SAH in patients with a nondiagnostic CT scan, although a negative result does not obviate the need for cerebrospinal fluid analysis.</td>
<td>Class IIb, Level C</td>
</tr>
<tr>
<td>New</td>
<td>7. DSA with 3-dimensional rotational angiography is indicated for detection of aneurysm in patients with aSAH (except when the aneurysm was previously diagnosed by a noninvasive angiogram) and for planning treatment (to determine whether an aneurysm is amenable to coiling or to expedite microsurgery).</td>
<td>Class I, Level B</td>
</tr>
<tr>
<td>New</td>
<td>8. Between the time of aSAH symptom onset and aneurysm obliteration, blood pressure should be controlled with a titratable agent to balance the risk of stroke, hypertension-related rebleeding, and maintenance of cerebral perfusion pressure.</td>
<td>Class I, Level B</td>
</tr>
<tr>
<td>New</td>
<td>9. The magnitude of blood pressure control to reduce the risk of rebleeding has not been established, but a decrease in systolic blood pressure to &lt;160 mm Hg is reasonable.</td>
<td>Class IIa, Level C</td>
</tr>
<tr>
<td>New</td>
<td>10. In the absence of a compelling contraindication, patients who undergo coiling or clipping of a ruptured aneurysm should have delayed follow-up vascular imaging (timing and modality to be individualized), and strong consideration should be given to retreatment, either by repeat coiling or microsurgical clipping, if there is a clinically significant (eg, growing) remnant.</td>
<td>Class I, Level B</td>
</tr>
<tr>
<td>New</td>
<td>11. Microsurgical clipping may receive increased consideration in patients presenting with large (&gt;50 mL) intraparenchymal hematomas and middle cerebral artery aneurysms. Endovascular coiling may receive increased consideration in the elderly (&gt;70 y of age), in those presenting with poor-grade WFNS classification (IV/V) aSAH, and in those with aneurysms of the basilar apex.</td>
<td>Class IIb, Level C</td>
</tr>
<tr>
<td>New</td>
<td>12. Stenting of a ruptured aneurysm is associated with increased morbidity and mortality.</td>
<td>Class III, Level C</td>
</tr>
<tr>
<td>New</td>
<td>13. Annual monitoring of complication rates for surgical and interventional procedures is reasonable.</td>
<td>Class IIa, Level C</td>
</tr>
<tr>
<td>New</td>
<td>14. A hospital credentialing process to ensure that proper training standards have been met by individual physicians treating brain aneurysms is reasonable.</td>
<td>Class IIa, Level C</td>
</tr>
<tr>
<td>New</td>
<td>15. Prophylactic hypervolemia or balloon angioplasty before the development of angiographic spasm is not recommended.</td>
<td>Class III, Level B</td>
</tr>
<tr>
<td>New</td>
<td>16. Transcranial Doppler is reasonable to monitor for the development of arterial vasospasm.</td>
<td>Class IIa, Level B</td>
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<tr>
<td>New</td>
<td>17. Perfusion imaging with CT or magnetic resonance can be useful to identify regions of potential brain ischemia.</td>
<td>Class IIa, Level B</td>
</tr>
<tr>
<td>New</td>
<td>18. Weaning EVD over &gt;24 hours does not appear to be effective in reducing the need for ventricular shunting.</td>
<td>Class III, Level B</td>
</tr>
<tr>
<td>New</td>
<td>19. Routine fenestration of the lamina terminalis is not useful for reducing the rate of shunt-dependent hydrocephalus and therefore should not be routinely performed.</td>
<td>Class III, Level B</td>
</tr>
<tr>
<td>New</td>
<td>20. Aggressive control of fever to a target of normothermia by use of standard or advanced temperature modulating systems is reasonable in the acute phase of aSAH.</td>
<td>Class IIa, Level B</td>
</tr>
<tr>
<td>New</td>
<td>21. The use of packed red blood cell transfusion to treat anemia might be reasonable in patients with aSAH who are at risk of cerebral ischemia. The optimal hemoglobin goal is still to be determined.</td>
<td>Class IIb, Level B</td>
</tr>
<tr>
<td>New</td>
<td>22. Heparin-induced thrombocytopenia and deep venous thrombosis are relatively frequent complications after aSAH. Early identification and targeted treatment are recommended, but further research is needed to identify the ideal screening paradigms.</td>
<td>Class I, Level B</td>
</tr>
<tr>
<td>Revised</td>
<td>1. For patients with an unavoidable delay in obliteration of aneurysm, a significant risk of rebleeding, and no compelling medical contraindications, short-term (&lt;72 hours) therapy with tranexamic acid or aminocaproic acid is reasonable to reduce the risk of early aneurysm rebleeding.</td>
<td>Class IIa, Level B</td>
</tr>
<tr>
<td>Revised</td>
<td>2. Determination of aneurysm treatment, as judged by both experienced cerebrovascular surgeons and endovascular specialists, should be a multidisciplinary decision based on characteristics of the patient and the aneurysm.</td>
<td>Class I, Level C</td>
</tr>
</tbody>
</table>
for de novo aneurysms or late regrowth of a treated aneurysm, but the risks and benefits of this screening require further study (Class IIb; Level of Evidence B).

7. After any aneurysm repair, immediate cerebrovascular imaging is generally recommended to identify remnants or recurrence of the aneurysm that may require treatment (Class I; Level of Evidence B). (New recommendation)

### Natural History and Outcome of aSAH

Although the case fatality of aSAH remains high worldwide, mortality rates from aSAH appear to have declined in industrialized nations over the past 25 years. One study in the United States reported a decrease of approximately 1% per year from 1979 to 1994. Others have shown that case fatality rates decreased from 57% in the mid-1970s to 42% in the mid-1980s, whereas rates from the mid-1980s to 2002 are reported to be anywhere from 26% to 36%. Regional variations become apparent when numbers from different studies are compared. The median mortality rate in epidemiological studies from the United States has been 32% versus 43% to 44% in Europe and 27% in Japan. These numbers are based on studies that did not always fully account for cases of prehospital death. This is an important consideration because the observed decrease in case fatality is related to improvements in survival among hospitalized patients with aSAH.

The mean age of patients presenting with aSAH is increasing, which has been noted to have a negative impact on survival rates. Sex and racial variations in survival may also play a role in the variable rates, with some studies suggesting higher mortality in women than in men and higher mortality in blacks, American Indians/Alaskan Natives, and Asians/Pacific Islanders than in whites.

Available population-based studies offer much less information about the functional outcome of survivors. Rates of persistent dependence of between 8% and 20% have been reported when the modified Rankin Scale is used. Although not population based, trial data show a similar picture, with 12% of patients in the International Subarachnoid Aneurysm Trial (ISAT) showing significant lifestyle restrictions (modified Rankin Scale 3) and 6.5% being functionally dependent (modified Rankin Scale score of 4–5) 1 year after aSAH. Furthermore, scales that are relatively insensitive to cognitive impairment, behavioral changes, social readjustment, and energy level may substantially underestimate the effect of aSAH on the function and quality of life of surviving patients. Multiple studies using diverse designs have consistently demonstrated that intellectual impairment is very prevalent after aSAH. Although cognitive function tends to improve over the first year, global cognitive impairment is still present in approximately 20% of aSAH patients and is associated with poorer functional recovery and lower quality of life. Cognitive deficits and functional decline are often compounded by mood disorders (anxiety, depression), fatigue, and sleep disturbances. Therefore, scales assessing well-being and quality of life can be particularly useful in the integral assessment of patients with aSAH, even among those who regain functional independence. Behavioral and psychosocial difficulties, as well as poor physical and mental endurance, are some of the most commonly encountered factors accounting for the inability of otherwise independent patients to return to their previous occupations.
reliably categorized by use of simple validated scales, such as the Hunt and Hess and World Federation of Neurological Surgeons scales. Aneurysm rebleeding is another major predictor of poor outcome, as discussed in a later section. Other factors predictive of poor prognosis include older age, preexisting severe medical illness, global cerebral edema on computed tomography (CT) scan, intraventricular and intracerebral hemorrhage, symptomatic vasospasm, delayed cerebral infarction (especially if multiple), hyperglycemia, fever, anemia, and other systemic complications such as pneumonia and sepsis. Certain aneurysm factors, such as size, location, and complex configuration, may increase the risk of periprocedural complications and affect overall prognosis. Treatment in high-volume centers with availability of neurosurgical and endovascular services may be associated with better outcomes.

Natural History and Outcome of aSAH: Recommendations

1. The initial clinical severity of aSAH should be determined rapidly by use of simple validated scales (eg, Hunt and Hess, World Federation of Neurological Surgeons), because it is the most useful indicator of outcome after aSAH (Class I; Level of Evidence B).

2. The risk of early aneurysm rebleeding is high, and rebleeding is associated with very poor outcomes. Therefore, urgent evaluation and treatment of patients with suspected aSAH is recommended (Class I; Level of Evidence B).

3. After discharge, it is reasonable to refer patients with aSAH for a comprehensive evaluation, including cognitive, behavioral, and psychosocial assessments (Class IIa; Level of Evidence B). (New recommendation)

Clinical Manifestations and Diagnosis of aSAH

The clinical presentation of aSAH is one of the most distinctive in medicine. The hallmark of aSAH in a patient who is awake is the complaint “the worst headache of my life,” which is described by approximately 80% of patients who can give a history. This headache is characterized as being extremely sudden and immediately reaching maximal intensity (thunderclap headache). A warning or sentinel headache that precedes the aSAH-associated ictus is also reported by 10% to 43% of patients. This sentinel headache increases the odds of early rebleeding 10-fold. Most intracranial aneurysms remain asymptomatic until they rupture. aSAH can occur during physical exertion or stress. Nevertheless, in a review of 513 patients with aSAH, the highest incidence of rupture occurred while patients were engaged in their daily routines, in the absence of strenuous physical activity. The onset of headache may be associated with additional signs and symptoms, including nausea and/or vomiting, stiff neck, photophobia, brief loss of consciousness, or focal neurological deficits (including cranial nerve palsies). In a retrospective study of 109 patients with proven aSAH, headache was present in 74%, nausea or vomiting in 77%, loss of consciousness in 53%, and nuchal rigidity in 35%. As many as 12% of patients die before receiving medical attention.

Despite the classic presentation of aSAH, individual findings occur inconsistently, and because the type of headache from aSAH is sufficiently variable, misdiagnosis or delayed diagnosis is common. Before 1985, misdiagnosis of aSAH occurred in as many as 64% of cases, with more recent data suggesting a misdiagnosis rate of 12%. Misdiagnosis was associated with a nearly 4-fold higher likelihood of death or disability at 1 year in patients with minimal or no neurological deficit at the initial visit. The most common diagnostic error is failure to obtain a noncontrast head CT scan. In a small subset of patients, a high degree of suspicion based on clinical presentation will lead to the correct diagnosis despite normal head CT and cerebrospinal fluid test results, as shown in a recent study in which 1.4% of patients were diagnosed with aSAH only after vascular imaging techniques were used.

Patients may report symptoms consistent with a minor hemorrhage before a major rupture, which has been called a sentinel bleed or warning leak. The majority of these minor hemorrhages occur within 2 to 8 weeks before overt aSAH. The headache associated with a warning leak is usually milder than that associated with a major rupture, but it may last a few days. Nausea and vomiting may occur, but meningismus is uncommon after a sentinel hemorrhage. Among 1752 patients with aneurysm rupture from 3 series, 340 (19.4%; range, 15%–37%) had a history of a sudden severe headache before the event that led to admission. The importance of recognizing a warning leak cannot be overemphasized. Headache is a common presenting chief complaint in the emergency department, and aSAH accounts for only 1% of all headaches evaluated in the emergency department. Therefore, a high index of suspicion is warranted, because diagnosis of the warning leak or sentinel hemorrhage before a catastrophic rupture may be lifesaving. Seizures may occur in up to 20% of patients after aSAH, most commonly in the first 24 hours and more commonly in aSAH associated with intracerebral hemorrhage, hypertension, and middle cerebral and anterior communicating artery aneurysms.

Noncontrast head CT remains the cornerstone of diagnosis of aSAH; since publication of the previous version of these guidelines, there have been only minor changes in imaging technology for this condition. The sensitivity of CT in the first 3 days after aSAH remains very high (close to 100%), after which it decreases moderately during the next few days. After 5 to 7 days, the rate of negative CT increases sharply, and lumbar puncture is often required to show xanthochromia. However, advances in magnetic resonance imaging of the brain, particularly the use of fluid-attenuated inversion recovery, proton density, diffusion-weighted imaging, and gradient echo sequences, can often allow the diagnosis of aSAH to be made when a head CT scan is negative and there is clinical suspicion of aSAH, possibly avoiding the need for lumbar puncture. The role of magnetic resonance imaging in perimesencephalic aSAH is controversial. Indications for magnetic resonance angiography in aSAH are still few because of limitations with routine
availability, logistics (including difficulty in scanning acutely ill patients), predisposition to motion artifact, patient compliance, longer study time, and cost. Aneurysms <3 mm in size continue to be unreliable demonstrated on computed tomographic angiography (CTA).\textsuperscript{105,106} and this generates continued controversy in the case of CTA-negative aSAH.\textsuperscript{107} In cases of perimesencephalic subarachnoid hemorrhage (SAH), some authors claim that a negative CTA result is sufficient to rule out aneurysmal hemorrhage and that cerebral angiography is not required, but this is controversial. In 1 study, the overall interobserver and intraobserver agreement for nonaneurysmal perimesencephalic hemorrhage was good, but there was still a level of disagreement among observers, which suggests that clinicians should be cautious when deciding whether to pursue follow-up imaging.\textsuperscript{108} In another study,\textsuperscript{109} a negative CTA result reliably excluded aneurysms when head CT showed the classic perimesencephalic SAH pattern or no blood. Digital subtraction angiography (DSA) was indicated if there was a diffuse aneurysmal pattern of aSAH, and repeat delayed DSA was required if the initial DSA findings were negative, which led to the detection of a small aneurysm in 14% of cases. When the blood is located in the sulci, CTA should be scrutinized for vasculitis, and DSA is recommended for confirmation.\textsuperscript{109} Others have shown that CTA may not reveal small aneurysms and that 2- and 3-dimensional cerebral angiography should be performed, especially when the hemorrhage is accompanied by loss of consciousness.\textsuperscript{110} In cases of diffuse aSAH pattern, most agree that negative CTA should be followed by 2- and 3-dimensional cerebral angiography. In older patients with degenerative vascular diseases, CTA can replace catheter cerebral angiography in most cases if the image quality is excellent and analysis is performed carefully.\textsuperscript{111} Overlying bone can be problematic with CTA, especially at the skull base. A new technique, CTA-MMBE (multisection CTA combined with matched mask bone elimination), is accurate in detecting intracranial aneurysms in any projection without superimposed bone.\textsuperscript{112} CTA-MMBE has limited sensitivity in detecting very small aneurysms. The data suggest that DSA and 3-dimensional rotational angiography can be limited to the vessel harboring the ruptured aneurysm before endovascular treatment after detection of a ruptured aneurysm with CTA. Another new technique, dual-energy CTA, has diagnostic image quality at a lower radiation dose than digital subtraction CTA and high diagnostic accuracy compared with 3-dimensional DSA (but not 2-dimensional DSA) in the detection of intracranial aneurysms.\textsuperscript{113}

Cerebral angiography is still widely used in the investigation of aSAH and the characterization of ruptured cerebral aneurysms. Although CTA is sometimes considered sufficient on its own when an aneurysm will be treated with surgical clipping,\textsuperscript{114} substantial controversy remains about the ability of CTA to determine whether or not an aneurysm is amenable to endovascular therapy.\textsuperscript{115–119} In 1 series,\textsuperscript{115} 95.7% of patients with aSAH were referred for treatment on the basis of CTA. In 4.4% of patients, CTA did not provide enough information to determine the best treatment, and those patients required DSA; 61.4% of patients were referred to endovascular treatment on the basis of CTA; and successful coiling was achieved in 92.6%. The authors concluded that CTA with a 64-slice scanner is an accurate tool for detecting and characterizing aneurysms in acute aSAH and that CTA is useful in deciding whether to coil or clip an aneurysm.\textsuperscript{115} Partial volume averaging phenomena may artificially widen the aneurysmal neck and may lead to the erroneous conclusion that an aneurysm cannot be treated by endovascular coiling. This controversy is likely caused by the different technological specifications (16- versus 64-detector rows), slice thickness, and data processing algorithms of various CT systems, which have different spatial resolutions. Three-dimensional cerebral angiography is more sensitive for detecting aneurysms than 2-dimensional angiography.\textsuperscript{121,122} The combination of 3- and 2-dimensional cerebral angiography usually provides the best morphological depiction of aneurysm anatomy with high spatial resolution, and it is, of course, always used in preparation for endovascular therapy.

Flat-panel volumetric CT is a relatively recent development that allows the generation of CT-like images from a rotational 3-dimensional spin of the x-ray gantry in the angiography room. For the moment, it has no substantial role in the initial diagnosis of aSAH because its spatial and contrast resolutions are not high enough;\textsuperscript{123} however, this technology can be used intraprocedurally during embolizations to rule out hydrocephalus.\textsuperscript{124} Recently, radiation dose has emerged as an important and worrisome consideration for patients with SAH.\textsuperscript{125,126} The combination of noncontrast head CT for the diagnosis of aSAH, confirmation of ventriculostomy placement, investigation of neurological changes, CTA for aneurysmal diagnosis, CTA and CT perfusion for recognition of vasospasm, and catheter cerebral angiography for aneurysm embolization and then for endovascular therapy of vasospasm can result in substantial radiation doses to the head, with possible risk of radiation injury, such as scalp erythema and alopecia. Although some or all of these radiological examinations are often necessary, efforts need to be made to reduce the amount of radiation exposure in patients with aSAH whenever possible.

Clinical Manifestations and Diagnosis of aSAH: Recommendations

1. aSAH is a medical emergency that is frequently misdiagnosed. A high level of suspicion for aSAH should exist in patients with acute onset of severe headache (Class I; Level of Evidence B).

2. Acute diagnostic workup should include noncontrast head CT, which, if nondiagnostic, should be followed by lumbar puncture (Class I; Level of Evidence B).

3. CTA may be considered in the workup of aSAH. If an aneurysm is detected by CTA, this study may help guide the decision for type of aneurysm repair, but if CTA is inconclusive, DSA is still recommended (except possibly in the instance of classic perimesencephalic aSAH) (Class IIb; Level of Evidence C). (New recommendation)

4. Magnetic resonance imaging (fluid-attenuated inversion recovery, proton density, diffusion-weighted imaging, and gradient echo sequences) may be reasonable for the diagnosis of aSAH in patients with a nondiagnostic CT scan, although a negative result

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\textsuperscript{http://stroke.ahajournals.org/}

\textsuperscript{Connolly et al Management of Aneurysmal Subarachnoid Hemorrhage}
does not obviate the need for cerebrospinal fluid analysis (Class IIb; Level of Evidence C). (New recommendation)

5. DSA with 3-dimensional rotational angiography is indicated for detection of aneurysm in patients with aSAH (except when the aneurysm was previously diagnosed by a noninvasive angiogram) and for planning treatment (to determine whether an aneurysm is amenable to coiling or to expedite microsurgery) (Class I; Level of Evidence B). (New recommendation)

Medical Measures to Prevent Rebleeding
After aSAH

Aneurysm rebleeding is associated with very high mortality and poor prognosis for functional recovery in survivors. The risk of rebleeding is maximal in the first 2 to 12 hours, with reported rates of occurrence between 4% and 13.6% within the first 24 hours. In fact, more than one third of rebleeds occur within 3 hours and nearly half within 6 hours of symptom onset, and early rebleeding is associated with worse outcome than later rebleeding. Factors associated with aneurysm rebleeding include longer time to aneurysm treatment, worse neurological status on admission, initial loss of consciousness, previous sentinel headaches (severe headaches lasting >1 hour that do not lead to the diagnosis of aSAH), larger aneurysm size, and possibly systolic blood pressure >160 mm Hg. Genetic factors, although related to the occurrence of intracranial aneurysms, do not appear to be related to an increased incidence of rebleeding. Early treatment of the ruptured aneurysm can reduce the risk of rebleeding. Among patients who present in a delayed manner and during the vasospasm window, delayed obliteration of aneurysm is associated with a higher risk of rebleeding than early obliteration of aneurysm.

There is general agreement that acute hypertension should be controlled after aSAH and until aneurysm obliteration, but parameters for blood pressure control have not been defined. A variety of titratable medications are available. Nicardipine may give smoother blood pressure control than labetalol and sodium nitroprusside, although data showing different clinical outcomes are lacking. Although lowering cerebral perfusion pressure may lead to cerebral ischemia, a cohort study of neurologically critically ill patients did not find an association between use of nicardipine and reduced brain oxygen tension. Clevidipine, a very short-acting calcium channel blocker, is another option for acute control of hypertension, but data for aSAH are lacking at this time. Antifibrinolytic therapy has been shown to reduce the incidence of aneurysm rebleeding when there is a delay in aneurysm obliteration. One referral center instituted a policy of short-term use of aminocaproic acid to prevent rebleeding during patient transfer. Such use led to a decreased incidence in rebleeding without increasing the risk of DCI, but 3-month clinical outcomes were not affected. There was an increased risk of deep venous thrombosis but not pulmonary embolism. Neither aminocaproic acid nor tranexamic acid is approved by the US Food and Drug Administration for prevention of aneurysm rebleeding.

Medical Measures to Prevent Rebleeding After aSAH: Recommendations

1. Between the time of aSAH symptom onset and aneurysm obliteration, blood pressure should be controlled with a titratable agent to balance the risk of stroke, hypertension-related rebleeding, and maintenance of cerebral perfusion pressure (Class I; Level of Evidence B). (New recommendation)

2. The magnitude of blood pressure control to reduce the risk of rebleeding has not been established, but a decrease in systolic blood pressure to <160 mm Hg is reasonable (Class IIa; Level of Evidence C). (New recommendation)

3. For patients with an unavoidable delay in obliteration of aneurysm, a significant risk of rebleeding, and no compelling medical contraindications, short-term (<72 hours) therapy with tranexamic acid or aminocaproic acid is reasonable to reduce the risk of early aneurysm rebleeding (Class IIa; Level of Evidence B). (Revised recommendation from previous guidelines)

Surgical and Endovascular Methods for Treatment of Ruptured Cerebral Aneurysms

Microsurgical clip obliteration of intracranial aneurysms was the primary modality of treatment before 1991, when Guglielmi first described occlusion of an aneurysm by an endovascular approach with electrolytically detachable coils. With advancements in both microsurgical and endovascular approaches, algorithms to determine the proper patient population and aneurysmal characteristics for each treatment are continually undergoing refinement. The only multicenter randomized trial comparing microsurgical and endovascular repair, ISAT, randomized 2143 of 9559 screened patients with aSAH across 42 neurosurgical centers. For a patient to be considered eligible for the trial, neurosurgeons and interventionists had to agree that the aneurysm was comparably suitable for treatment with either modality. Primary outcomes included death or dependent living, and secondary outcomes included risk of seizures and risk of rebleeding. Initial 1-year outcomes revealed a reduction in death and disability from 31% in the microsurgery arm to 24% in the endovascular arm (relative risk reduction, 24%). This difference was mainly driven by a decrease in the rate of disability among survivors (16% in the endovascular arm and 22% in the craniotomy arm) and was likely attributable at least in part to the greater incidence of technical complications in the clipping (19%) versus the coiling (8%) arms and the longer time needed to secure the aneurysm. The risk of epilepsy and significant cognitive decline was also reduced in the endovascular group, but the incidence of late rebleeding (2.9% after endovascular repair versus 0.9% after open surgery) was higher in the endovascular arm, and only 58% of coiled aneurysms were completely obliterated compared with 81% of clipped aneurysms. A large retrospective analysis found that the rate of incomplete occlusion and subsequent aneurysm recurrence depended critically on neck diameter and dome size. It can also be difficult to achieve complete obliteration in very small aneurysms (<3 mm), with 1 study...
reporting no coils deployed in 5% of cases, residual dome filling or a neck remnant in 30%, and a higher procedural complication rate than in larger aneurysms. 144

Although the complete obliteration rate can be increased by the addition of a high-porosity stent, this has been associated with an increased risk of complications, especially in patients with SAH, in large part because of the need for periprocedural dual-antiplatelet therapy to prevent arterial thromboembolism. 145 Whether low-porosity flow-diverting stents with or without coils represent a better option for many or most of those presenting with SAH from saccular aneurysms remains to be studied, but these stents make more conceptual sense for use in the patient with a dissecting aneurysm, in whom vessel sacrifice is not an option and microsurgical solutions carry higher risk.

Another approach to increasing complete obliteration rates involves the deployment of biologically active rather than pure platinum coils. 146 Although uncontrolled studies suggest a potential reduction in the risk of recurrence, these data are preliminary and have yet to be confirmed in prospective controlled trials. 147,148 Thus, although the short-term efficacy of endovascular coil obliteration is well established compared with microsurgical approaches, close long-term surveillance continues to be warranted, because durability remains a significant concern. 149

Given this delicate balance between safety and durability, there have been multiple efforts to identify subgroups of patients who might be best treated with endovascular or microsurgical techniques. Although the quality of the data is modest, most agree that with current endovascular technology, middle cerebral artery aneurysms can be difficult to treat with coil embolization, and in this location, surgical treatment has tended to yield more favorable results. 146,150-152 Although some have suggested that older patients are ideal candidates for clipping rather than clipping, data on this population are sparse and at times conflicting. 141,153,154 Although patients presenting with an intraparenchymal hematoma > 50 mL have a higher incidence of unfavorable outcome, hematoma evacuation within <3.5 hours has been shown to improve outcome in this subgroup and argues in favor of microsurgery for most patients with large parenchymal clots. 155 By contrast, patients presenting during the vasospasm period, especially those with confirmed vasospasm, may be better treated with endovascular techniques, depending on the anatomy of the aneurysm and its relationship to the spasm. 150 Patients presenting with poor clinical grade appear to benefit more from endovascular clipping, especially if they are also elderly, because advanced age renders long-term durability less important. 156

Still, it is critical that patients with poor clinical grade be treated in centers where both modalities are available. 157

Endovascular treatment of posterior circulation aneurysms has been gaining widespread acceptance based on several observational studies. A meta-analysis revealed that the mortality from clipping of a basilar bifurcation aneurysm was 0.9%, and the risk of permanent complications was 5.4%. 158 More recently, with regard to treatment of posterior circulation aneurysms, the mortality and morbidity in 112 ruptured aneurysms was 3.7% and 9.4%, respectively. 159 These data have led to an increasing tendency toward clipping ruptured posterior circulation aneurysms. One study that compared clipping versus coiling of basilar apex aneurysm (44 patients in each treatment arm) found a poor outcome rate of 11% in the endovascular treatment group versus 30% in the surgical group. In that study, the main difference was the rate of ischemia and hemorrhage during the surgical intervention. The rates of recurrent hemorrhage and delayed ischemia were actually similar in both groups. 159

Incomplete aneurysm occlusion and recurrent aneurysm filling from progressive coil compaction are particularly difficult challenges encountered with endovascular treatment of basilar artery aneurysms. In a study of 41 posterior circulation aneurysms, 35 (85%) had complete or near-complete immediate angiographic occlusion. The follow-up time frame for this study was 17 months, and of the 29 patients for whom follow-up was obtained, those with completely occluded aneurysms did not reveal any compaction. In the remaining patients who had near-complete occlusion, 47% had experienced recanalization, with 1 patient experiencing a rehemorrhage. 160 On the basis of these findings, closer follow-up with sequential DSA is needed in patients who undergo clipping of posterior circulation aneurysms, particularly those who do not exhibit complete occlusion on immediate follow-up angiography.

Surgical and Endovascular Methods of Treatment of Ruptured Cerebral Aneurysms: Recommendations

1. Surgical clipping or endovascular coiling of the ruptured aneurysm should be performed as early as feasible in the majority of patients to reduce the rate of rebleeding after aSAH (Class I; Level of Evidence B).

2. Complete obliteration of the aneurysm is recommended whenever possible (Class I; Level of Evidence B).

3. Determination of aneurysm treatment, as judged by both experienced cerebrovascular surgeons and endovascular specialists, should be a multidisciplinary decision based on characteristics of the patient and the aneurysm (Class I; Level of Evidence C). (Revised recommendation from previous guidelines)

4. For patients with ruptured aneurysms judged to be technically amenable to both endovascular clipping and neurosurgical clipping, endovascular clipping should be considered (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)

5. In the absence of a compelling contraindication, patients who undergo coiling or clipping of a ruptured aneurysm should have delayed follow-up vascular imaging (timing and modality to be individualized), and strong consideration should be given to retreatment, either by repeat coiling or microsurgical clipping, if there is a clinically significant (eg, growing) remnant (Class I; Level of Evidence B). (New recommendation)

6. Microsurgical clipping may receive increased consideration in patients presenting with large (>50 mL) intraparenchymal hematomas and middle cerebral artery aneurysms. Endovascular clipping may receive increased consideration in the elderly (>70 years of age), in those presenting with poor-grade
Hospital Characteristics and Systems of Care

In a US study of 31,476 nontraumatic cases of aSAH from 2003, definitive aneurysm repair was delivered in fewer than one third of cases. That said, the adjusted odds of definitive repair were significantly higher in urban teaching hospitals than in urban nonteaching hospitals (odds ratio, 1.62) or rural hospitals (odds ratio, 3.08). In another study from 1993 to 2003, teaching status and larger hospital size were associated with higher charges and longer stay but also with better outcomes (P < 0.05) and lower mortality rates (P < 0.05), especially in patients who underwent aneurysm clipping (P < 0.01). Endovascular treatment, which was more often used in the elderly, was also associated with significantly higher mortality rates in smaller hospitals (P < 0.001) and steadily increasing morbidity rates (45%). Large academic centers were associated with better results, particularly for surgical clip placement. Prior studies have also indicated that 82% of US hospitals admitted <19 patients with aSAH annually, and the 30-day mortality rate was significantly higher in hospitals that admitted <10 patients with aSAH versus >35 patients with aSAH (39% versus 27%; odds ratio, 1.4).80

Two factors associated with better outcomes were greater use of endovascular services and a higher percentage of patients transferred from other hospitals. Institutions that used endovascular coil embolization more frequently had lower in-hospital mortality rates, a 9% reduction in risk for every 10% of cases treated. In addition, there was a 16% reduction in risk of in-hospital death at institutions that used interventional therapies such as balloon angioplasty to treat arterial vasospasm. Therefore, hospital treatment volumes and availability of both endovascular and neurological intensive care services at hospitals are important determinants of improved outcomes in aSAH. In addition, a cost-utilty analysis estimated that transferring a patient with aSAH from a low- to a high-volume hospital would result in a gain of 1.6 quality-adjusted life-years at a cost of $10,548.162,163

Although 1 study suggested that care was uniformly delivered within an institution when weekend and weekday admissions were compared, others have shown that intensive care specialists followed evidence-based recommendations very inconsistently, and these variations in practice did not depend on the quality of the supporting data. Significant practice differences were noted between respondents from North America and Europe and between those working in high- and low-volume centers. Thus, the study demonstrated that the practices of intensive care unit physicians treating aSAH are heterogenous and often at variance with available evidence.165

One recent effort to increase the uniformity of care is the development of an Accreditation Council on Graduate Medical Education-approved fellowship training program for endovascular surgical neuroradiology. Another effort is legislation or regulation in >10 states that defines elements of comprehensive stroke centers and their role in networks and stroke systems of care. The Brain Attack Coalition paper that proposed the establishment of these centers included management of aSAH in its scope. From the endovascular perspective, this expertise includes the ability to treat patients with intracranial aneurysms, SAH-induced vasospasm, brain arteriovenous malformations, and ischemic stroke. Other important required elements of these centers are vascular neurosurgical expertise, dedicated intensive care units, and 24/7 access to advanced neuroimaging. The rationale for comprehensive stroke centers is based on the success of similar models for trauma.

Anesthetic Management During Surgical and Endovascular Treatment

The general goals of anesthetic management involve hemodynamic control to minimize the risk of aneurysm rupture and strategies to protect the brain against ischemic injury. Although induced hypotension has been used in the past to prevent aneurysm rupture, data suggest that there could be potential harm, with an increased risk of early and delayed neurological deficits. A retrospective study suggests that a decrease in mean arterial pressure of >50% is associated with poor outcome; however, after adjustment for age, this association was no longer statistically significant. In patients undergoing cerebral aneurysm surgery, intraoperative hyperglycemia has been associated with long-term decline in cognition and gross neurological function. These associations are seen at levels of hyperglycemia commonly encountered in practice, with increased risk of alterations in cognition with glucose concentrations >129 mg/dL and neurological deficits with glucose concentrations >152 mg/dL. Numerous pharmacological agents have been used to promote cerebral protection during cerebral aneurysm sur-
surgery,172–181 but none have been clearly shown to improve outcome.

Systemic hypothermia has been used in several clinical settings, including head injury, ischemic stroke, and circulatory arrest, to protect the brain against ischemic injury.182–188 Use of hypothermia during craniotomy for the treatment of ruptured cerebral aneurysm was evaluated in a multicenter randomized, controlled trial. The study showed that hypothermia was relatively safe but was not associated with a beneficial effect in mortality or neurological outcome among patients with good-grade aSAH.189 In addition, intraoperative hypothermia had no beneficial effect on neuropsychological outcome.190 Of note, the power of these 2 studies was not sufficient to detect more modest benefits from hypothermia, and there were some trends in favor of hypothermia for secondary end points.

Temporary clipping is frequently used to improve surgical conditions and prevent intraoperative rupture during the surgical dissection of aneurysms. In a retrospective study, outcome was not affected by temporary vascular occlusion.191 Induced hypertension can be considered when the duration of temporary clipping is expected to be >120 seconds, but the value of this strategy has not been well studied in aneurysm surgery. In selected patients with giant aneurysms, deep hypothermia with circulatory arrest under cardiopulmonary extracorporeal circulation has been shown to be a feasible and possibly useful technique, but outcome data are lacking.192–196 Transient cardiac pause induced by adenosine has been used to control bleeding from intraoperative aneurysm rupture or to decompress large aneurysms and facilitate aneurysm clip application197,198; however, controlled studies are needed to validate this intervention.

There is little information in the literature about anesthetic management of patients undergoing endovascular treatment of ruptured cerebral aneurysms.199–201 Generally, the anesthetic principles that apply to open surgical treatment of ruptured cerebral aneurysms also apply to endovascular treatment. The choice of anesthetic technique varies depending on the institution, with the most common techniques being conscious sedation and general anesthesia.202–204 There have been no studies comparing these 2 techniques. One of the main goals of the anesthetic technique is keeping the patient motionless to optimize the quality of the images used to perform the endovascular procedure; hence, general anesthesia with endotracheal intubation is often preferred for these procedures.

Intraoperative aneurysm rupture during endovascular treatment presents a major challenge unlike that encountered with open craniotomy. There may be a sudden and massive rise in blood pressure with or without bradycardia attributable to an elevation in intracranial pressure. Hyperventilation and osmotic diuresis may be required to control the intracranial hypertension. Aggressive treatment of surges in blood pressure may induce ischemia; therefore, antihypertensive therapy should be reserved for patients with extreme elevations in blood pressure.

Endovascular procedures differ from open procedures in that anticoagulation with heparin is frequently administered during the embolization of aneurysms. Patients who have undergone anticoagulation require rapid reversal with protamine if intra procedural aneurysm rupture occurs. With the increasing use of intravascular stents, the administration of antiplatelet agents (aspirin, clopidogrel, and glycoprotein Ib/IIa receptor antagonists) during these procedures has become more common. In case of intra procedural rupture, rapid reversal of antiplatelet activity can be attempted by platelet transfusion.

Anesthetic Management During Surgical and Endovascular Treatment: Recommendations

1. Minimization of the degree and duration of intraoperative hypotension during aneurysm surgery is probably indicated (Class IIa; Level of Evidence B).

2. There are insufficient data on pharmacological strategies and induced hypertension during temporary vessel occlusion to make specific recommendations, but there are instances when their use may be considered reasonable (Class III; Level of Evidence C).

3. Induced hypothermia during aneurysm surgery is not routinely recommended but may be a reasonable option in selected cases (Class III; Level of Evidence B).

4. Prevention of intraoperative hyperglycemia during aneurysm surgery is probably indicated (Class IIa; Level of Evidence B).

5. The use of general anesthesia during endovascular treatment of ruptured cerebral aneurysms can be beneficial in selected patients (Class IIa; Level of Evidence C).

Management of Cerebral Vasospasm and DCI After aSAH

Narrowing (vasospasm) of the angiographically visible cerebral arteries after aSAH is common, occurring most frequently 7 to 10 days after aneurysm rupture and resolving spontaneously after 21 days. The cascade of events culminating in arterial narrowing is initiated when oxyhemoglobin comes in contact with the abluminal side of the vessel.205 The pathways leading to arterial narrowing have been the focus of extensive basic research, but no effective preventive therapy has been developed to date. Part of the reason for this lack of success likely stems from the fact that vasospasm occurs at multiple levels in the arterial and arteriolar circulation. Large artery narrowing seen in angiographically visible vessels only results in ischemic neurological symptoms in 50% of cases, and although there is a correlation between the severity of large artery spasm and symptomatic ischemia, there are patients with severe large artery spasm who never become symptomatic and others with quite modest spasm who not only develop symptoms but go on to develop infarction.206 Probably many factors contribute to the development of ischemia and infarction, including but not limited to distal microcirculatory failure, poor collateral anatomy, and genetic or physiological variations in cellular ischemic tolerance.207,208

DCI, especially that associated with arterial vasospasm, remains a major cause of death and disability in patients with aSAH. The management of aSAH-induced vasospasm is complex. Many significant advances in the understanding of aSAH-induced vasospasm and DCI have been made since
publication of the previous version of these guidelines, which focused on prevention with oral nimodipine and maintenance of euvelnena, as well as treatment with triple-H therapy (hemodynamic augmentation therapy) and/or endovascular therapy with vasodilators and angioplasty balloons. First, the case for nimodipine is even stronger, with a recent comprehensive meta-analysis confirming improved neurological outcomes by preventing processes other than large-vessel narrowing. Although there have been sparse new important data on the lack of benefit for prophylactic hypervolemia compared with maintenance of euvelnena, new data show that both prophylactic angioplasty of the basal cerebral arteries and antiplatelet prophylaxis are ineffective in reducing morbidity. Similarly, the only supportive data for the use of lumbar drainage come from a single case-control study, although there is ongoing investigation on the value of this intervention to reduce arterial spasm and DCI.

The data are a bit better for intrathecal thrombolytic infusions, with a recent meta-analysis of 5 randomized, controlled trials suggesting a benefit despite some methodological weaknesses. There are also emerging data for several novel methods to reduce the incidence and ischemic consequences of aSAH-induced vasospasm. These new approaches are based on robust experimental data that indicate a critical role for endothelial dysfunction, particularly at the microcirculatory level.

Several recent clinical trials have investigated the utility of statins, endothelin-1 antagonists, and magnesium sulfate. Statin agents have been studied in several small, single-center randomized trials with variable results. Although a recent meta-analysis reported no evidence for clinical benefit, a larger phase 3 trial (SimvasTatin in AneurySmal Subarachnoid Hemorrhage [STASH]) is in progress. Clazosentan, an endothelin-1 receptor antagonist, had been shown to be associated with a dose-dependent reduction in the incidence of angiographic vasospasm in a phase IIb trial (Clazosentan to Overcome Neurological IsChemia and Infarct OcCurring after Subarachnoid hemorrhage [CONSCIOUS-1]). A benefit for clinical outcomes was not initially apparent but then was judged present when a stricter definition of vasospasm-related stroke was used. However, a subsequent trial (CONSCIOUS-2) that tested the drug in patients treated with aneurysm clipping found no improvement in clinical outcome in the clazosentan group. Magnesium sulfate has been studied in several pilot trials. Although there is some suggestion of reduction in delayed ischemic deficits associated with magnesium infusion, a benefit has not been conclusively shown in a meta-analysis. A phase 3 trial (Intravenous Magnesium sulfate for AneurySmal Subarachnoid Hemorrhage [IMASH]) did not support any clinical benefit from magnesium infusion over placebo in aSAH.

A larger randomized trial is under way. When DCI is diagnosed, the initial treatment is the induction of hemodynamic augmentation to improve cerebral perfusion. No randomized trials of this intervention have been performed, but the rapid improvement of many patients with this therapy and their worsening when it is stopped prematurely are convincing proof of efficacy. The exact mechanism of benefit is unclear. In some patients, increased mean arterial pressures may increase cerebral blood flow in the setting of autoregulatory dysfunction. In others, there may be some direct transluminal pressure effect that leads to arterial dilation. Traditionally, hemodynamic augmentation has consisted of modulation (a common occurrence in this population), hypervolemia, and hypertensive therapy. Accumulating literature has shifted the focus from this triple-H therapy to the maintenance of euvelnena and induced hypertension.

One novel method of hemodynamic augmentation under investigation is an aortic balloon device, approved under a humanitarian device exemption. Endovascular intervention is often used in patients who do not improve with hemodynamic augmentation and those with sudden focal neurological deficits and focal lesions on angiography referable to their symptoms. Interventions generally consist of balloon angioplasty for accessible lesions and vasodilator infusion for more distal vessels. Many different vasodilators are in use. In general, these are calcium channel blockers, but nitric oxide donors have been used in small series as well. Papaverine is used less frequently because it can produce neurotoxicity. The primary limitation of vasodilator therapy is the short duration of benefit. As with hemodynamic augmentation, there have been no randomized trials of these interventions, but large case series have demonstrated angiographic and clinical improvement.

Management of Cerebral Vasospasm and DCI After aSAH: Recommendations

1. Oral nimodipine should be administered to all patients with aSAH (Class I; Level of Evidence A). (It should be noted that this agent has been shown to improve neurological outcomes but not cerebral vasospasm. The value of other calcium antagonists, whether administered orally or intravenously, remains uncertain.)

2. Maintenance of euvelnena and normal circulating blood volume is recommended to prevent DCI (Class...
Management of Hydrocephalus Associated With aSAH

Acute hydrocephalus occurs in 15% to 87% of patients with aSAH.334–340 Chronic shunt-dependent hydrocephalus, on the other hand, occurs in 8.9% to 48% of patients with aSAH.334–338,240–244 There is only 1 randomized, controlled trial pertaining to the management of hydrocephalus associated with aSAH245 and 2 meta-analyses236,241; the rest of the literature consists of nonrandomized case-control, case series, or case reports. Acute hydrocephalus associated with aSAH is usually managed by external ventricular drainage (EVD) or lumbar drainage. EVD for patients with aSAH-associated hydrocephalus is generally associated with neurological improvement.246–248 The risk of aneurysm rebleeding with EVD has been studied in 3 retrospective case series, 1 of which found a higher risk of rebleeding with EVD,249 whereas the other 2 studies found no increased risk.250,251 Lumbar drainage for the treatment of aSAH-associated hydrocephalus has been reported to be safe (no increase in the risk of rebleeding), but it has only been examined in retrospective series.214,252–255 1 of which specifically evaluated intraoperative lumbar drainage for brain relaxation.256 The theoretical risk of tissue shift after placement of a lumbar drain in patients with severe intracranial hypertension should be considered when deciding what method of cerebrospinal fluid diversion to use, particularly in patients with associated intraparenchymal hematomas. When obstructive hydrocephalus is suspected, an EVD should be preferred. Preliminary data have suggested that lumbar drainage is associated with reduced incidence of vasospasm.214,255 Serial lumbar punctures to manage acute aSAH-associated hydrocephalus have been described as safe, but this strategy has only been assessed in small retrospective series.239,257 Chronic hydrocephalus associated with aSAH is usually treated with ventriculotamponade shunt placement. Only a proportion of patients with aSAH-associated acute hydrocephalus develop shunt-dependent chronic hydrocephalus. The method of determining which patients require ventricular shunt placement was studied in a single-center, prospective, randomized, controlled trial in which 41 patients were randomized to rapid weaning of EVD (mean period 24 minutes) and 40 patients were randomized to gradual EVD weaning (mean period 24 hours).245 There was no difference in the rate of shunt placement (63.4% rapid versus 62.5% gradual), but the gradual wean group had 2.8 more days in the intensive care unit (P = 0.0002) and 2.4 more days in the hospital (P = 0.0314).245

A number of retrospective series have attempted to identify factors predictive of aSAH-associated shunt-dependent chronic hydrocephalus.235,236,240,242 A meta-analysis336 of 5 nonrandomized studies236,258–261 with 1718 pooled patients (1336 who underwent clipping, 382 who underwent coiling) found a lower risk of shunt dependency in the clipping group (relative risk, 0.74; 95% confidence interval, 0.58–0.94) than in the coiling group (P = 0.01); however, only 1 of the 5 studies showed an independent significant difference.258 Three other nonrandomized series not included in the meta-analysis showed no significant difference between clipping and coiling in shunt-dependent chronic hydrocephalus.237,244,262 Fenestration of the lamina terminalis has been suggested to reduce the incidence of shunt-dependent chronic hydrocephalus, yet a meta-analysis243 of 11 nonrandomized studies234,260,263–271 pooled 1973 patients (975 who had undergone fenestration and 998 who had not) and found no significant difference in shunt-dependent hydrocephalus between patients who had undergone fenestration of the lamina terminalis and those who had not (10% in the fenestrated cohort versus 14% in the nonfenestrated cohort; P = 0.09). A nonrandomized study not included in the meta-analysis compared 95 patients who underwent aneurysm clipping, cisternal blood evacuation, and lamina terminalis fenestration with 28 comparable, non–blood-cleansed, endovascular therapy–treated patients and found that shunt-dependent hydrocephalus occurred in 17% of surgical patients versus 33% of patients treated with endovascular therapy (statistical significance not reported).256

Management of Hydrocephalus Associated With aSAH: Recommendations

1. aSAH-associated acute symptomatic hydrocephalus should be managed by cerebrospinal fluid diversion (EVD or lumbar drainage, depending on the clinical scenario) (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)

2. aSAH-associated chronic symptomatic hydrocephalus should be treated with permanent cerebrospinal fluid diversion (Class I; Level of Evidence C). (Revised recommendation from previous guidelines)

3. Weaning EVD over >24 hours does not appear to be effective in reducing the need for ventricular shunting (Class III; Level of Evidence B). (New recommendation)

4. Routine fenestration of the lamina terminalis is not useful for reducing the rate of shunt-dependent hydrocephalus and therefore should not be routinely
Management of Seizures Associated With aSAH

The incidence, future implications, and management of seizures associated with aSAH are controversial. At present, no randomized, controlled trials are available to guide decisions on prophylaxis or treatment of seizures. A relatively high percentage of aSAH patients (as many as 26%) experience seizure-like episodes, but it remains unclear whether these episodes are verifiably epileptic in origin. More recent retrospective reviews suggest a lower seizure incidence of 6% to 18%, and 2 of these studies found that the majority of such patients reported onset of seizure occurring before medical evaluation. Delayed seizures occurred in 3% to 7% of patients. Retroactive studies have identified several risk factors for the development of early seizures associated with aSAH, including aneurysm in the middle cerebral artery, thickness of aSAH clot, associated intracerebral hematoma, rebleeding, infarction, poor neurological grade, and history of hypertension.

The mode of treatment for patients with ruptured aneurysms also appears to influence the subsequent development of seizures. One study of patients treated by endovascular means reported no periprocedural seizures and a delayed seizure rate of 3%. Moreover, extended follow-up of patients enrolled in the ISAT demonstrated a significantly lower incidence of seizures in patients treated with endovascular coiling. The association between seizures and functional outcome remains unclear. Some studies have reported no impact on outcome, whereas others found seizures to be independently associated with worse outcome.

Two recent large, retrospective, single-institution studies of patients with aSAH found that nonconvulsive status epilepticus is a very strong predictor of a poor outcome. Although high-quality evidence for routine anticonvulsant use in aSAH is lacking, short-term prophylactic antiepileptic therapy is still commonly used in patients with aSAH, based on the argument that seizures in acutely ill patients with aSAH could lead to additional injury or rebleeding from an unsecured aneurysm. Evidence from a few relatively small nonrandomized studies of craniotomy patients supports this position, but the efficacy of routine use of anticonvulsants in patients with aSAH managed with microsurgical techniques remains unproven.

Any purported benefit of routine anticonvulsant use in aSAH must be tempered by a consideration of the potential risks of such use. In 1 large single-institution study in which anticonvulsants were used routinely, adverse drug effects were seen in 23% of patients. Another single-center retrospective study found that the use of prophylactic phenytoin was independently associated with a worse cognitive outcome at 3 months after aSAH. Data pooled from trials of the impact of other therapies also suggest a worse outcome in those treated with anticonvulsants, but use of anticonvulsants was also associated with vasospasm, DCI, and fever, which suggests that there may have been bias in who was treated with antiepileptic drugs. Although retrospective studies have not demonstrated a benefit for use of prophylactic anticonvulsants after aSAH, the studies were small and hampered by limitations (eg, anticonvulsant levels were not routinely monitored).

Management of Seizures Associated With aSAH: Recommendations

1. The use of prophylactic anticonvulsants may be considered in the immediate posthemorrhagic period.

2. The routine long-term use of anticonvulsants is not recommended but may be considered for patients with known risk factors for delayed seizure disorder, such as prior seizure, intracerebral hematoma, intractable hypertension, infarction, or aneurysm at the middle cerebral artery.

Management of Medical Complications Associated With aSAH

Both hypernatremia and hyponatremia are frequently observed in the acute phase after aSAH. The reported incidence of hyponatremia in this disease ranges from 10% to 30%. Hypernatremia has been chronologically associated with the onset of sonographic and clinical vasospasm. Hyponatremia can develop from different mechanisms after aSAH. The syndrome cerebral salt wasting is produced by excessive secretion of natriuretic peptides and causes hyponatremia from excessive natriuresis, which may also provoke volume contraction. The diagnosis of cerebral salt wasting is more common in patients with poor clinical grade, ruptured anterior communicating artery aneurysms, and hydrocephalus, and it may be an independent risk factor for poor outcome.

Uncontrolled studies using crystalloid or colloid agents suggest that aggressive volume resuscitation can ameliorate the effect of cerebral salt wasting on the risk of cerebral ischemia after aSAH. One retrospective study has suggested that 3% saline solution is effective in correcting hyponatremia in this setting. In addition, use of hypertonic saline solution appears to increase regional cerebral blood flow, brain tissue oxygen, and pH in patients with high-grade aSAH.

Two randomized, controlled trials have been performed to evaluate fluidorocortisones to correct hyponatremia and fluid balance. One trial found that it helped to correct the negative sodium balance, and the other reported a reduced need for fluids and improved sodium levels using this mineralocorticoid. A similar randomized, placebo-controlled trial showed reduced natriuresis and a lower rate of hyponatremia in aSAH patients treated with hydrocortisone. The value of albumin as an efficient volume expander during the vasospasm phase in aSAH has been suggested in uncontrolled studies, but there is no clear evidence of its superiority over crystalloids in patients with aSAH.

Fever is the most common medical complication in aSAH. The presence of fever of noninfectious (central) origin has been associated with severity of injury, amount of hemorrhage, and development of vasospasm, and it may represent a marker of a systemic inflammatory state triggered by...
by blood and its byproducts. Analysis of data from a prospectively collected registry of aSAH indicated that fever was independently associated with worse cognitive outcome in survivors of aSAH. Improved functional outcome with effective control of fever has been reported. Both animal studies and human case series have demonstrated an association between elevated blood glucose concentration and poor outcome after ischemic brain injury. The mechanisms explaining such an association in human beings are unclear. Data obtained from consecutive patients with aSAH using historical controls to compare aggressive versus standard management of hyperglycemia suggest that effective glucose control after aSAH can significantly reduce the risk of poor outcome in these patients. Nevertheless, even serum glucose levels within the normal range may be associated with brain energy metabolic crisis and lactate-pyruvate ratio elevation in patients with poor-grade aSAH.

Anemia is common after aSAH and may compromise brain oxygen delivery. Transfusion of red blood cells in anemic patients with aSAH results in a significant rise in cerebral oxygen delivery and a reduction in oxygen extraction ratio. Data obtained from prospective registries of patients with aSAH suggest that higher hemoglobin values are associated with improved outcomes after aSAH. Nevertheless, thresholds for blood transfusion have been dictated in a nonsystematic manner and have therefore varied widely. Furthermore, red blood cell transfusions, as used in daily practice, have been associated with worse outcomes in aSAH in some series. Recently, a prospective randomized trial has shown the safety and feasibility of keeping a higher hemoglobin goal in patients with aSAH who are at high risk of vasospasm. The optimal hemoglobin goal after aSAH is not yet known, however.

Two additional medical complications are heparin-induced thrombocytopenia and deep venous thrombosis. With regard to the former, the incidence, based on single-center series, is likely 5% and does not appear to be related to the use of heparin for deep venous thrombosis prophylaxis, but rather to the number of angiographic procedures performed. Patients with heparin-induced thrombocytopenia type II appear to have higher rates of thrombotic complications and symptomatic vasospasm/DCI, more deaths, and significantly less favorable outcomes. It is currently unclear whether there is a practical means of preventing heparin-induced thrombocytopenia, given the need for heparin in many angiographic procedures, but it is clearly important to recognize this complication to avoid further heparin exposure and to use instead a nonheparin alternative under the guidance of a hematologist. By comparison, deep venous thrombosis has long been recognized as a relatively frequent occurrence after aSAH, especially in patients immobilized because of poor mental status. Nevertheless, in examining cohorts in which routine prophylaxis (subcutaneous heparinoids and external pneumatic compression sleeves) was used, recent data suggest that although screening protocols may identify additional cases of asymptomatic thrombosis, there is no significant difference in the incidence of pulmonary embolism between those screened and those not screened.

**Management of Medical Complications Associated With aSAH: Recommendations**

1. Administration of large volumes of hypotonic fluids and intravascular volume contraction is not recommended after aSAH (Class III; Level of Evidence B).
2. Monitoring volume status in certain patients with recent aSAH by some combination of central venous pressure, pulmonary wedge pressure, and fluid balance is reasonable, as is treatment of volume contraction with crystalloid or colloid fluids (Class IIa; Level of Evidence B).
3. Aggressive control of fever to a target of normothermia by use of standard or advanced temperature modulating systems is reasonable in the acute phase of aSAH (Class IIa; Level of Evidence B). (New recommendation)
4. Careful glucose management with strict avoidance of hypoglycemia may be considered as part of the general critical care management of patients with aSAH (Class IIb; Level of Evidence B).
5. The use of packed red blood cell transfusion to treat anemia might be reasonable in patients with aSAH who are at risk of cerebral ischemia. The optimal hemoglobin goal is still to be determined (Class IIb; Level of Evidence B). (New recommendation)
6. The use of fludrocortisone, acetate and hypertonic saline solution is reasonable for preventing and correcting hyponatremia (Class IIa; Level of Evidence B).
7. Heparin-induced thrombocytopenia and deep venous thrombosis are relatively frequent complications after aSAH. Early identification and targeted treatment are recommended, but further research is needed to identify the ideal screening paradigms (Class I; Level of Evidence B). (New recommendation)

**Summary and Conclusions**

The management of aSAH is a complex undertaking, and the current state of knowledge is in rapid evolution. This update, which is based on a mere 42 months of publications, identified 22 new recommendations (Table 4), 5 of which were Class I recommendations. There were also 9 changes in prior recommendations. In total, there are now 22 Class I recommendations (Table 3). Although these data show that frequent revision of these guidelines is clearly needed, the data presented here only begin to scratch the surface of the burgeoning knowledge in this fast-developing field. Those faced with managing these patients will thus do well to use these guidelines as merely the starting point for doing everything possible to improve the outcomes of patients with aSAH.
### Disclosures

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Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association


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Aneurysmal subarachnoid hemorrhage (aSAH) is a significant cause of morbidity and mortality throughout the world. Although aggressive medical and surgical care for this disease has resulted in marked improvements in outcomes for those fortunate enough to be admitted to tertiary care centers experienced in handling this disease, many patients still die before hospitalization, and many others are treated in low-volume centers, where their medical and surgical options may be limited. Thus, although efforts continue to focus on developing better methods for treating patients with aSAH, considerable energy has been and will continue to be focused on primary and secondary prevention and systems of care.

This Executive Summary contains only the recommendations from the 2012 Guidelines for the Management of Aneurysmal Subarachnoid Hemorrhage. The previous version of the guidelines was published in 2009. The 2012 version serves to update those guidelines. As such, differences from former recommendations are specified in the present work. The writing group met by telephone to determine subcategories to evaluate. These subcategories included incidence, risk factors, prevention, natural history and outcome, diagnosis, prevention of rebleeding, management of vasospasm, management of hydrocephalus, management of seizures, and management of medical complications. Each subcategory was led by 1 author, with 1 or 2 additional authors who made contributions. Full MEDLINE searches were conducted of all English-language papers on treatment of relevant human disease. Drafts of summaries and recommendations were circulated to the entire writing group for feedback. A conference call was held to discuss controversial issues. Sections were revised and merged by the writing group chair. The resulting draft was sent to the entire writing group for comment. Comments were incorporated into the draft by the writing group chair and vice chair, and the entire writing group was asked to approve the final draft. The chair and vice chair revised the document in response to peer review, and the document was again sent to the entire writing group for suggestions and approval.

The recommendations follow the American Heart Association Stroke Council’s methods of classifying the level of certainty of the treatment effect and the class of evidence (Tables 1 and 2). This Executive Summary includes all recommendations, 22 of which are new and 9 of which were revised from the prior manuscript. In total, 22 of the recommendations are categorized as Class I recommendations. Two of the Class I recommendations are based on Level A evidence, and 2 are based on Level C evidence. The remainder of the Class I recommendations are based on Level B evidence.

Recommendations

Risk Factors for and Prevention of aSAH

- Treatment of high blood pressure with antihypertensive medication is recommended to prevent
ischemic stroke, intracerebral hemorrhage, and cardiac, renal, and other end-organ injury (Class I; Level of Evidence A).

- Hypertension should be treated, and such treatment may reduce the risk of aSAH (Class I; Level of Evidence A).

- Tobacco use and alcohol misuse should be avoided to reduce the risk of aSAH (Class I; Level of Evidence B).

- In addition to the size and location of the aneurysm and the patient’s age and health status, it might be reasonable to consider morphological and hemodynamic characteristics of the aneurysm when discussing the risk of aneurysm rupture (Class IIb; Level of Evidence B). (New recommendation)

- Consumption of a diet rich in vegetables may lower the risk of aSAH (Class IIb; Level of Evidence B). (New recommendation)

- It may be reasonable to offer noninvasive screening to patients with familial (at least 1 first-degree relative) aSAH and/or a history of aSAH to evaluate for de novo aneurysms or late regrowth of a treated aneurysm, but the risks and benefits of this screening require further study (Class IIb; Level of Evidence B).
After any aneurysm repair, immediate cerebrovascular imaging is generally recommended to identify remnants or recurrence of the aneurysm that may require treatment (Class I; Level of Evidence B). (New recommendation)

**Natural History and Outcome of aSAH**

- The initial clinical severity of aSAH should be determined rapidly by use of simple validated scales (eg, Hunt and Hess, World Federation of Neurological Surgeons), because it is the most useful indicator of outcome after aSAH (Class I; Level of Evidence B).
- The risk of early aneurysm rebleeding is high, and rebleeding is associated with very poor outcomes. Therefore, urgent evaluation and treatment of patients with suspected aSAH is recommended (Class I; Level of Evidence B).
- After discharge, it is reasonable to refer patients with aSAH for a comprehensive evaluation, including cognitive, behavioral, and psychosocial assessments (Class IIa; Level of Evidence B). (New recommendation)

**Clinical Manifestations and Diagnosis of aSAH**

- aSAH is a medical emergency that is frequently misdiagnosed. A high level of suspicion for aSAH should exist in patients with acute onset of severe headache (Class I; Level of Evidence B).
- Acute diagnostic workup should include noncontrast head computed tomography, which, if nondiagnostic, should be followed by lumbar puncture (Class I; Level of Evidence B).
- Computed tomographic angiography may be considered in the workup of aSAH. If an aneurysm is detected by computed tomographic angiography, this study may help guide the decision for type of aneurysm repair, but if computed tomographic angiography is inconclusive, digital subtraction angiography is still recommended (except possibly in the instance of classic perimesencephalic aSAH) (Class IIb; Level of Evidence C). (New recommendation)
- Magnetic resonance imaging, fluid-attenuated inversion recovery, proton density, diffusion-weighted imaging, and gradient echo sequences may be reasonable for the diagnosis of aSAH in patients with a nondiagnostic computed tomographic scan, although a negative result does not obviate the need for cerebrospinal fluid analysis (Class IIb; Level of Evidence C). (New recommendation)
- Digital subtraction angiography with 3-dimensional rotational angiography is indicated for detection of aneurysm in patients with aSAH (except when the aneurysm was previously diagnosed by a noninvasive angiogram) and for planning treatment (to determine whether an aneurysm is amenable to coiling or to expedite microsurgery) (Class I; Level of Evidence B). (New recommendation)

**Medical Measures to Prevent Rebleeding After aSAH**

- Between the time of aSAH symptom onset and aneurysm obliteration, blood pressure should be controlled with a titratable agent to balance the risk of stroke, hypertension-related rebleeding, and maintenance of cerebral perfusion pressure (Class I; Level of Evidence B). (New recommendation)
- The magnitude of blood pressure control to reduce the risk of rebleeding has not been established, but a decrease in systolic blood pressure to <160 mm Hg is reasonable (Class IIa; Level of Evidence C). (New recommendation)
- For patients with an unavoidable delay in obliteration of aneurysm, a significant risk of rebleeding, and no compelling medical contraindications, short-term (<72 hours) therapy with tranexamic acid or aminocaproic acid is reasonable to reduce the risk of early aneurysm rebleeding (Class IIa; Level of Evidence B). (Revised recommendation from previous guidelines)
Surgical and Endovascular Methods of Treatment of Ruptured Cerebral Aneurysms

- Surgical clipping or endovascular coiling of the ruptured aneurysm should be performed as early as feasible in the majority of patients to reduce the rate of rebleeding after aSAH (Class I; Level of Evidence B).
- Complete obliteration of the aneurysm is recommended whenever possible (Class I; Level of Evidence B).
- Determination of aneurysm treatment, as judged by both experienced cerebrovascular surgeons and endovascular specialists, should be a multidisciplinary decision based on characteristics of the patient and the aneurysm (Class I; Level of Evidence C). (Revised recommendation from previous guidelines)
- For patients with ruptured aneurysms judged to be technically amenable to both endovascular coiling and neurosurgical clipping, endovascular coiling should be considered (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)
- In the absence of a compelling contraindication, patients who undergo coiling or clipping of a ruptured aneurysm should have delayed follow-up vascular imaging (timing and modality to be individualized), and strong consideration should be given to retreatment, either by repeat coiling or microsurgical clipping, if there is a clinically significant (eg, growing) remnant (Class I; Level of Evidence B). (New recommendation)
- Microsurgical clipping may receive increased consideration in patients presenting with large (≥50 mL) intraparenchymal hematomas and middle cerebral artery aneurysms. Endovascular coiling may receive increased consideration in the elderly (≥70 years of age), in those presenting with poor-grade (World Federation of Neurological Societies classification IV/V) aSAH, and in those with aneurysms of the basilar apex (Class IIb; Level of Evidence C). (New recommendation)
- Stenting of a ruptured aneurysm is associated with increased morbidity and mortality, and should only be considered when less risky options have been excluded (Class III; Level of Evidence C). (New recommendation)

Hospital Characteristics and Systems of Care

- Low-volume hospitals (eg, <10 aSAH cases per year) should consider early transfer of patients with aSAH to high-volume centers (eg, >35 aSAH cases per year) with experienced cerebrovascular surgeons, endovascular specialists, and multidisciplinary neuro-intensive care services (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)
- Annual monitoring of complication rates for surgical and interventional procedures is reasonable (Class IIa; Level of Evidence C). (New recommendation)
- A hospital credentialing process to ensure that proper training standards have been met by individual physicians treating brain aneurysms is reasonable (Class IIa; Level of Evidence C). (New recommendation)

Anesthetic Management During Surgical and Endovascular Treatment

- Minimization of the degree and duration of intraoperative hypotension during aneurysm surgery is probably indicated (Class IIa; Level of Evidence B).
- There are insufficient data on pharmacological strategies and induced hypertension during temporary vessel occlusion to make specific recommendations, but there are instances when their use may be considered reasonable (Class IIb; Level of Evidence C).
- Induced hypothermia during aneurysm surgery is not routinely recommended but may be a reasonable option in selected cases (Class III; Level of Evidence B).
- Prevention of intraoperative hyperglycemia during aneurysm surgery is probably indicated (Class IIa; Level of Evidence B).
- The use of general anesthesia during endovascular treatment of ruptured cerebral aneurysms can be beneficial in selected patients (Class IIa; Level of Evidence C).

Management of Cerebral Vasospasm and Delayed Cerebral Ischemia After aSAH

- Oral nimodipine should be administered to all patients with aSAH (Class I; Level of Evidence A). (It should be noted that this agent has been shown to improve neurological outcomes but not cerebral vasospasm. The value of other calcium antagonists, whether administered orally or intravenously, remains uncertain.)
- Maintenance of euvoemia and normal circulating blood volume is recommended to prevent delayed cerebral ischemia (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)
- Prophylactic hypervolemia or balloon angioplasty before the development of angiographic spasm is not recommended (Class III; Level of Evidence B). (New recommendation)
- Transcranial Doppler is reasonable to monitor for the development of arterial vasospasm (Class IIa; Level of Evidence B). (New recommendation)
- Perfusion imaging with computed tomography or magnetic resonance can be useful to identify regions of potential brain ischemia (Class IIa; Level of Evidence B). (New recommendation)
- Induction of hypertension is recommended for patients with delayed cerebral ischemia unless blood pressure is elevated at baseline or cardiac status precludes it (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)
• Cerebral angioplasty and/or selective intra-arterial vasodilator therapy is reasonable in patients with symptomatic cerebral vasospasm, particularly those who are not rapidly responding to hypertensive therapy (Class IIa; Level of Evidence B). (Revised recommendation from previous guidelines)

Management of Hydrocephalus Associated With aSAH

• aSAH-associated acute symptomatic hydrocephalus should be managed by cerebrospinal fluid diversion (external ventricular drainage or lumbar drainage, depending on the clinical scenario) (Class I; Level of Evidence B). (Revised recommendation from previous guidelines)
• aSAH-associated chronic symptomatic hydrocephalus should be treated with permanent cerebrospinal fluid diversion (Class I; Level of Evidence C). (Revised recommendation from previous guidelines)
• Weaning external ventricular drainage over >24 hours does not appear to be effective in reducing the need for ventricular shunting (Class III; Level of Evidence B). (New recommendation)
• Routine fenestration of the lamina terminalis is not useful for reducing the rate of shunt-dependent hydrocephalus and therefore should not be routinely performed (Class III; Level of Evidence B). (New recommendation)

Management of Seizures Associated With aSAH

• The use of prophylactic anticonvulsants may be considered in the immediate posthemorrhagic period (Class IIb; Level of Evidence B).
• The routine long-term use of anticonvulsants is not recommended (Class III; Level of Evidence B) but may be considered for patients with known risk factors for delayed seizure disorder, such as prior seizure, intracerebral hematoma, intractable hypertension, infarction, or aneurysm at the middle cerebral artery (Class IIb; Level of Evidence B).

Management of Medical Complications Associated With aSAH

• Administration of large volumes of hypotonic fluids and intravascular volume contraction is not recommended after aSAH (Class III; Level of Evidence B).
• Monitoring volume status in certain patients with recent aSAH by some combination of central venous pressure, pulmonary wedge pressure, and fluid balance is reasonable, as is treatment of volume contraction with crystalloid or colloid fluids (Class IIa; Level of Evidence B).
• Aggressive control of fever to a target of normothermia by use of standard or advanced temperature modulating systems is reasonable in the acute phase of aSAH (Class IIa; Level of Evidence B). (New recommendation)
• Careful glucose management with strict avoidance of hypoglycemia may be considered as part of the general critical care management of patients with aSAH (Class IIb; Level of Evidence B).
• The use of packed red blood cell transfusion to treat anemia might be reasonable in patients with aSAH who are at risk of cerebral ischemia. The optimal hemoglobin goal is still to be determined (Class IIb; Level of Evidence B). (New recommendation)
• The use of fludrocortisone acetate and hypertonic saline solution is reasonable for preventing and correcting hyponatremia (Class IIa; Level of Evidence B).
• Heparin-induced thrombocytopenia and deep venous thrombosis are relatively frequent complications after aSAH. Early identification and targeted treatment are recommended, but further research is needed to identify the ideal screening paradigms (Class I; Level of Evidence B). (New recommendation)

References

References are available in the full text of this guideline: http://stroke.ahajournals.org/lookup/doi/10.1161/STR.0b013e3182587839.

1. aSAHの発症率と罹病率
これまでaSAHの発症率に地域差があることが報告されていたが、近年のレビューでもaSAHの発症率がフィンランドと日本で高く、中米・南米で低いことが示され、世界的には人口10万人につき年間2〜16例と推定されている。

2. aSAHの危険因子と予防（表2）
高血圧、喫煙、過度の飲酒、交感神経作用薬（コカインなど）はaSAHの危険因子であるが、未破裂脳動脈瘤、aSAHの既往、脳動脈瘤の家族歴、家族性多嚢胞性腎やIV型Ehlers-Danlos症候群などもaSAHのリスクを増加させる。予防としてaSAH患者の第二度近親者をスクリーニングすることは妥当かもしれない。また野菜が豊富な食事によりaSAHのリスクが低下することが報告されている。

3. aSAHの自然経過と転帰（表3）
aSAHの死亡率（中央値）は米国32％、欧州43％、日本27％と報告されている。機能的転帰の臨床的調査は少ないが、変化Ranckin Scale（mRS）で常に介助が必要な生存者は8〜20％とされる。さらに、aSAH後には認知障害が20％くらいにみられ、不十分な機能回復や低いQOLと結びついている。aSAHの予後予測の最も強い指標は臨床的重症度であり、Hunt and HessやWorld Federation of Neurological Surgeons（WFNS）スケールで迅速に分類できる。動脈瘤の再出血は不良な転帰の予測因子である。

4. aSAHの臨床徵候と診断（表4）
aSAHの頭痛は突発性で瞬時にピークに達する激痛（thunderclap headache：雷鳴頭痛）が特徴である。aSAHの前に、より軽度の警告頭痛（sentinel headache）が10〜43％に起こる。頭部単純CTはaSAH診断の要であり、発症後3日以内では感度は100％に近いが、発症後5〜7日後には脳脊髄液検査の必要が生じる。磁気共鳴画像法（MRI）は頭部CTが陰性の症例にaSAHの診断をつかうことを可能にしていく。CT血管造影は3mm以下の動脈瘤検出に問題があるが、CTAの単独検査で十分なことはある。二次元と二次元血管造影の併用は、空間分解能が高い動脈瘤の描出に最適である。

5. aSAH後の再出血を防ぐための内科的処置（表5）
脳動脈瘤の再出血は死亡率と不良な転帰をもたらす。早期の動脈瘤治療が再出血のリスクを低減させるので、迅速な対応が必要である。aSAH後の急性期高血圧は動脈瘤が閉塞されるまでコントロールされるべきであるが、血圧管理の詳細は決めていない。用量調節が可能な薬物としてはニカルジピン、ラベタロール、ニトロプルシドがある。動脈瘤開塞が遅延する場合、短期の抗線維素溶営療法が再出血のリスクを低減するとされている。
6. 破裂脳動脈瘤の脳外科的治療と血管内治療（表 6）
ISAT 試験では 2,143 例で開頭クリッピング術と血管内コイル塞栓術が無作為試験で比較され、1 年後の死亡率はクリッピング群が高かった（31% 対 24%）。遅発性再出血のリスクもクリッピング群で高く（2.9% 対 0.9%）。脳動脈瘤の完全閉塞はクリッピング群で高かった（81% 対 58%）。血管内コイル塞栓術の短期効果は確立されているが、持続性について懸念があるため、長期に経過観察を続ける必要がある。血管内治療と開頭手術の選択において、中大脳動脈瘤はクリッピング術が傾向があった。年齢が 70 才以上で、脳動脈瘤の完全閉塞はクリッピング群で高かった（81% 対 58%）。血管内治療の短期効果は確立されているが、持久性について懸念があるため、長期に経過観察を続ける必要がある。
血管内治療と顕微鏡下手術の選択については、中大脳動脈瘤はクリッピング術の成績が良い傾向があり、老齢者にはクリッピング術よりコイル塞栓術が良いことが示唆されている。大きな脳実質内血腫（> 50 mL）を伴う症例には、血腫除去が可能であることから、開頭クリッピング術が好まれる。血管攣縮を発症した症例には、血管内治療が選ばれる。臨床的グレードの悪い症例、特に老齢患者では、治療の持続性が若年者ほど重要でないため、血管内治療が適しているとされる。後方循環系の動脈瘤に対しては、クリッピング術に比べて死亡率と合併症が低いことから、血管内治療が広く受け入れられている。脳底動脈瘤に対する血管内治療では、動脈瘤の不完全閉塞とコイル圧縮による動脈瘤の再発が起こるため、DAS でフォローする必要がある。

7. 病院の特徴と診療体制（表 7）
脳動脈瘤クリッピング術を受けた患者では、教育病院や大規模病院において良好な転帰と低い死亡率が得られ、血管内治療でも同様の結果が示されている。aSAH 症例数と血管内治療および神経系集中治療室の存在が良好な転帰の重要な決定因子であると考えられる。米国では脳血管系の血管内治療教育プログラムの認定制度と総合脳卒中センターの制定により、blood flow 増強療法および血管拡張薬とバルーン血管形成術に焦点があてられた。その後 nimodipine については、総合的メタ解析で神経学的転帰の改善が確認された。一方、脳底動脈瘤に対する予防的な血管形成術と抗血小板薬の予防的投与は罹患率を低下させなかった。脳脊髄液ドレナージによる血管挿入率と DCI の抑制効果は、症例コントロール研究でのみ示されている。DCI の中心、局所低流量を検出しやすい循環流動性、動脈硬化を検出しやすい解剖学的画像、血流速度の変化を検出す循環特性が示され、そのうち循環流動性がより正確であるとされるが、新たなデータが示される。DCI が診断されること、最初の治療は脳循環を改善するための血行動態増強療法である。この治療法には無作為試験が行っているが、導入後の速やかに改善と早期の治療中止による悪化に説得力がある。これまでは血行動態増強療法は血行動態、循環血液量増加、高血圧からなっていたが、最近では高血圧の維持と高血圧の導入を勧める文献が増えている。血行動態増強療法に反応しない症例や突然に局所神経脱落徵候を観察し、血管造影で血管挿入を認める症例にはバルーン血管形成術と動脈末梢部への血管拡張薬の注入が施行される。血管拡張薬としてはカルシウムギャシャー拮抗薬に一部使われる。ジャンピニンは神経毒性のため使用されている。

8. 脳外科治療と血管内治療の麻酔管理（表 8）
麻酔管理のゴールは、脳動脈瘤破裂時リスクを減らす血行動態管理と、脳循環機能障害を防ぐ処置が含まれる。低血圧により動脈瘤破裂を防ぐ試みがあるが、低血圧時には早期および遅延性神経脱落徵候出現のリスクがある。脳動脈瘤手術中の高血圧は長期の認知機能や神経機能の低下を招く。破裂動脈瘤の開頭手術において低体温の効果が検討され、低体温は比較的安全であるものの、臨床グレードの良い症例では死亡率や転帰に影響はなかった。術中の動脈瘤破壊を防ぐため、一時的に動脈閉塞と昇圧が導入されるが、その効果はまだ十分評価されていない。特定の巨大脳動脈瘤患者に超低体温と循環停止/体外心肺循環の導入が可能であるが、転帰についてのデータが乏しい。血管内治療を受ける患者の麻酔管理の文献は少ないが、破裂脳動脈瘤の開頭手術の麻酔管理の原則があらためて示される。血管内治療における麻醉の目的の 1 つは、血管内処置に用いる画像撮像のためであり、全身麻酔が選ばれることが多い。

9. aSAH に関連した動脈脳動揺と遅発性脳虚血の管理（表 9）
血管造影でみられる脳動脈の狭小化（vasospasm : 血管脳動揺）は aSAH 後 7 ~ 10 日に最もよく起こり、21 日後には消失する。血管造影でみられる主幹動脈の狭小化のうち虚血性神経脱落徵候は 50% にしかみられないが、遅発性脳虚血（DCI）、特に血管挿入率に連関した DCI は死亡と重度機能障害の主な原因となる。前回のガイドラインでは、予防法としてステチ nimodipine と正常血液量の維持、治療には 3-H 療法（血行動態増強療法）および血管拡張薬とバルーン血管形成術に焦点があてられた。その後 nimodipine については、総合的メタ解析で神経学的転帰の改善が確認された。一方、脳底動脈瘤に対する予防的な血管形成術と抗血小板薬の予防的投与は罹患率を低下させなかった。脳脊髄液ドレナージによる血管挿入率と DCI の抑制効果は、症例コントロール研究でのみ示されている。DCI の同定には、局所低流量を検出す循環画像、動脈硬化を検出す解剖学的画像、血流速度の変化を検出す経頭蓋血管造影が示されるが、そのうち循環流動性がより正確であるとされる。これまでの血行動態増強療法は血行動態、循環血液量増加、高血圧からなっていたが、最近では高血圧の維持と高血圧の導入を勧める文献が増えている。血行動態増強療法に反応しない症例や突然に局所神経脱落徵候を観察し、血管造影で血管挿入を認める症例にはバルーン血管形成術と動脈末梢部へ血管拡張薬の注入が施行される。血管拡張薬としてはカルシウムギャシャー拮抗薬に一部使われる。ジャンピニンは神経毒性のため使用されている。

10. aSAH に関連した水頭症の管理（表 10）
急性水頭症は aSAH 患者の 15 ~ 87% に起こり、シャントを必要とする慢性水頭症は aSAH 患者の 8.9 ~ 48% に起こるとされる。aSAH 関連の急性水頭症は脳室外ドレナージ（EVD）または腹腔ドレナージ（LD）で治療される。LD は再出血のリスクを高めないとされるが、後向き調査が行われていない。著明な頭蓋内圧亢進のある症例、特に脳実質内血腫のある患者では、LD 留
置後に脳組織がシフトする可能性がある。慢性水頭症は通常脳室シャント術によって治療される。脳室シャント術につき、EVDの＜24時間使用群と96時間使用群が無作為コントロール試験で比較されたが、シャント術の必要性（63.4％対62.5％）に差は認められなかった。終板（lamina terminalis）開窓術がシャントを必要とする慢性水頭症を減らすことが報告されているが、1,733例を対象とした11件の非無作為試験のメタ解析では間違術の有無とシャントの必要性に関連がなかった。

11. aSAHに関連した痙攣発作の管理（表11）
急性期の痙攣発作の頻度は6〜18％とされ、発作性の痙攣発作も3〜7％のaSAH患者にみられる。早期脳機能発作の危険因子としては、脳動脈瘤、aSAHの厚み、脳内血腫の存在、再出血、梗塞が考えられる。日常的な抗痙攣薬の投与を支持する根拠は明らかではなく、aSAH急性期の痙攣は脳損傷を悪化させ、未治療動脈瘤からの再出血を起こす可能性があるとの議論から、短期の抗痙攣薬の投与が一般に行われている。

12. aSAHに関連した内科的合併症の管理（表12）
低ナトリウム血症はaSAH後10〜30%の症例にみられる。aSAHによる脳実質を減少し、水分を排出するため、脳実質の水分量が減少し、循環血液量が減少を起こすこととなる。循環血液量を回復させるため、3%食塩水が示唆されている。発熱はaSAHで最も高頻度にみられる内科的合併症である。非感染性（中枢性）の発熱は脳損傷の重症度、出血量、血管損傷の発現と関連している。aSAH後の高血糖の積極的な管理が不良な転帰のリスクを低減させることを示唆されている。高血糖はaSAH後に起こることが、ヘモグロビンを高値に保つことが転帰の改善につながるとの報告がある。しかしあSAH後の最適なヘモグロビン値は未定である。ヘパリン起因性血小板減少症患者には血栓性合併症、血小板減少、DIC、不良な転帰、死亡がより高い頻度で起こる。深部静脈血栓症の発症はaSAH後比較的よく起こる。深部静脈血栓症のスクリーニングは無症候性血栓症の発見に有用であるが、スクリーニングの有無によって肺塞栓症の頻度は変わらない。

以下に掲載される表には、次の略語が用いられている。
aSAH：aneurysmal subarachnoid hemorrhage（脳動脈瘤によるくも膜下出血）
CSF：cerebrospinal fluid（脳脊髄液）
CTA：computed tomography angiography（CT血管造影）
DCI：delayed cerebral ischemia（遅発性脳虚血）
DSA：digital subtraction angiography（デジタルサブトラクション血管造影）
EVD：external ventricular drainage（脳室外ドレナージ）

表1 AHA Stroke Councilの推奨に用いられているエビデンスの分類とレベルの定義

<table>
<thead>
<tr>
<th>クラス</th>
<th>定義</th>
</tr>
</thead>
</table>
| クラスI | 手技または治療法の有用性および有効性を示すエビデンス。または一般的合意がある。
| クラスII | 手技または治療法の有用性および有効性に関して相互されるエビデンス。または意見の相違がある。
| クラスIIa | 手技または治療法を指示するエビデンス。または意見がある。
| クラスIIb | エビデンスまたは意見による有用性および有効性の確立が十分である。
| クラスIII | 手技または治療法の有用性および有効性がなく、場合によっては有害となりうることを示すエビデンス。または一般的合意がある。

治療に関する推奨
<table>
<thead>
<tr>
<th>エビデンスレベル</th>
<th>定義</th>
</tr>
</thead>
<tbody>
<tr>
<td>エビデンスレベルA</td>
<td>無作為臨床試験データまたはメタ解析から得られたデータ</td>
</tr>
<tr>
<td>エビデンスレベルB</td>
<td>1つの無作為臨床試験または複数の非無作為試験から得られたデータ</td>
</tr>
<tr>
<td>エビデンスレベルC</td>
<td>専門家の意見、症例研究または標準的な治療</td>
</tr>
</tbody>
</table>

診断に関する推奨
<table>
<thead>
<tr>
<th>エビデンスレベル</th>
<th>定義</th>
</tr>
</thead>
<tbody>
<tr>
<td>エビデンスレベルA</td>
<td>独立化された評価者が設定した参照基準を用いた診断</td>
</tr>
<tr>
<td>エビデンスレベルB</td>
<td>単一の基準を、1つ以上の症例対照研究、または診断化されていない評価者が設定した参照基準を用いた診断</td>
</tr>
<tr>
<td>エビデンスレベルC</td>
<td>専門家の意見</td>
</tr>
</tbody>
</table>
表2 aSAHの危険因子と予防に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 虚血性脳卒中、脳内出血および心臓、腎臓およびその他の末梢器官障害を防ぐため、降圧薬による高血圧治療が推奨される。</td>
<td>クラスI エビデンスレベルA</td>
</tr>
<tr>
<td>2. 高血圧は治療しなければならず、そのような治療によってaSAHのリスクを軽減することが考えられる。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>3. aSAHのリスクを軽減するためには、喫煙およびアルコールの乱用を避けるべきである。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>4. 動脈瘤破裂のリスクを検討する際には、動脈瘤のサイズや位置ならびに患者の年齢や健康状態に加え、動脈瘤の形態学的な血行力学的特性が重要である。</td>
<td>新規推奨</td>
</tr>
<tr>
<td>5. 野菜が豊富な食事は、aSAHのリスクを軽減する効果がある。</td>
<td>新規推奨</td>
</tr>
<tr>
<td>6. 家族性（少なくとも第一度近親者）aSAHおよびaSAHの既往がある患者については、非侵襲的なスクリーニング検査を実施して新規動脈瘤または治療済み動脈瘤の再発の有無を評価することを考慮しても良い</td>
<td>クラスIIb エビデンスレベルB</td>
</tr>
<tr>
<td>7. 動脈瘤の治療計画の作成の際には、動脈瘤の形態学的な特性が重要である。</td>
<td>クラスIIb エビデンスレベルB</td>
</tr>
</tbody>
</table>

表3 aSAHの自然経過と転帰に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aSAHの初期の臨床的重症度はaSAH後の転帰の最も有用な指標であるため、検証済みの簡便な尺度（例えばHunt and Hessの分類、World Federation of Neurological Surgeons分類）を用いて迅速に判定すべきである。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>2. 早期の動脈瘤再出血のリスクは高く、再出血をきたした場合には転帰は極めて不良である。したがって、aSAHが疑われる患者では迅速に評価し治療を行うことが推奨される。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>3. 退院後、aSAH患者には認知、行動、心理社会的評価も含めた、総合的な評価を勧めることが妥当である。</td>
<td>新規推奨</td>
</tr>
</tbody>
</table>

表4 aSAHの臨床徵候と診断に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aSAHは医学的に緊急を要する病態であるが、診断される症例も多い。激しい頭痛が突然起こった患者では、aSAHを強く疑うべきである。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>2. 迅速診断のための検査には頭部単純CT検査を含めるが、この検査で診断がつかない場合は次いで腰椎穿刺を実施すべきである。</td>
<td>クラスI エビデンスレベルB</td>
</tr>
<tr>
<td>3. aSAHの精密検査においてはCTAを考慮してもよろしい。 CTAで動脈瘤が検出された場合には、この検査を動脈瘤修復方法の決定に役立て、CTAで結節が見つかなかった場合にはDSAの実施が推奨される（よく中国のあなたが Sahの症例は例外であろう）。</td>
<td>クラスIIb エビデンスレベルC</td>
</tr>
<tr>
<td>4. 磁気共鳴画像（フレアーオン、プロトン密度強調画像、拡散強調画像およびグラディエントエコー）は、CTスキャンで診断がつかない症例におけるaSAHの診断に有効かもしれないが、結果が陰性であってもCSF検査の必要性は除外されない。</td>
<td>クラスIIb エビデンスレベルC</td>
</tr>
<tr>
<td>5. 三元性のCT血管撮影を用いたDSAは、aSAH患者の動脈瘤の検討（動脈瘤が非侵襲的血管撮影で診断済みの場合を除く）および治療計画の作成（動脈瘤にカテーテル治療または顕微鏡下手術が実施可能か否かを判断）に推奨される。</td>
<td>新規推奨</td>
</tr>
</tbody>
</table>

表5 aSAH発症後の再出血を防ぐための内科的処置に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aSAH症状の発現時点から動脈瘤閉塞までの期間は、用量調節可能な薬物を用いて血圧を管理し、脳卒中、高血圧による再出血のリスク、および脳欲塩基維持のバランスを保つ必要がある。</td>
<td>新規推奨</td>
</tr>
<tr>
<td>2. 再出血のリスクを軽減するためにどのような程度の血圧管理が必要かは確定されていないが、収縮期圧は&lt; 160 mmHgに抑えることが妥当である。</td>
<td>新規推奨</td>
</tr>
<tr>
<td>3. 動脈瘤塞栓術を遅らせざるを得ず、再出血のリスクが高く、また医学的にやむを得ない滅多がない患者については、トラガノプレ網またはアミノプロプラいている短期治療（&lt; 72時間）が、早期の動脈瘤再出血のリスク軽減のために妥当である。（前ガイドラインの推奨を改訂）</td>
<td>新規推奨</td>
</tr>
</tbody>
</table>
### 表6 破裂脳動脈瘤の外科的治療と血管内治療に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 大多数の患者では、破裂脳動脈瘤の外科的クリッピング術または血管内コイル塞栓術を可能な限り早期に実施し、aSAH後の再出血率を抑えるべきである。</td>
<td>クラスⅠ、エビデンスレベルB</td>
</tr>
<tr>
<td>2. 脳動脈瘤は可能な限り、完全閉塞することが望ましい。</td>
<td>クラスⅠ、エビデンスレベルB</td>
</tr>
<tr>
<td>3. 経験豊富な脳血管外科医と血管内治療専門医の両者が決定する動脈瘤の治療法は、患者と動脈瘤の特性に基づいた、総合的な判断でなければならない。（前ガイドラインの推奨を改訂）</td>
<td>クラスⅠ、エビデンスレベルC</td>
</tr>
<tr>
<td>4. 破裂動脈瘤に対して血管内コイル塞栓術と脳外科的クリッピング術の両方が技術的に実施可能と判断された患者については、血管内コイル塞栓術が考慮されるべきである。（前ガイドラインの推奨を改訂）</td>
<td>クラスⅠ、エビデンスレベルB</td>
</tr>
<tr>
<td>5. やむを得ぬ禁忌がない場合、破裂脳動脈瘤にコイリングまたはクリッピング術を受けた患者はフォローのため血管造影検査を術後実施（時期と様式は個別に決定する）。臨床的に重大な（例えば増大しつつある）残存瘤が認められる場合には、再度のコイリングまたは顕微鏡下でのクリッピング術のいずれかによる再治療を強く考慮しなければならない。（前ガイドラインの推奨を改訂）</td>
<td>クラスⅠ、エビデンスレベルB</td>
</tr>
<tr>
<td>6. 大きな（&gt;50mL）実質内血腫および中大脳動脈瘤を呈する患者においては、顕微鏡下でのクリッピング術が優先して考慮されても良いろう。血管内コイル塞栓術は、高齢患者（年齢70歳以上）、グレードが高い（World Federation of Neurological Surgeons分類IV/V）aSAHを呈する高齢患者、および脳底動脈先端部に動脈瘤を認める高齢患者において、優先的に考慮されても良いろう。（新規推奨）</td>
<td>クラスⅡb、エビデンスレベルC</td>
</tr>
<tr>
<td>7. 破裂動脈瘤へのステント留置術は罹病率、死亡率が高いため、リスクが低い選択肢がない場合にのみ検討すべきである。（新規推奨）</td>
<td>クラスⅢ、エビデンスレベルC</td>
</tr>
</tbody>
</table>

### 表7 病院の特徴と診療体制に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 小規模病院（例えば1年間にaSAHが10例未満）は、aSAH患者を、経験豊富な脳血管外科医、血管内治療専門医および専門的神経集中治療室を備えた大規模病院（例えば1年間にaSAHが35例以上）へ早期に搬送することを検討すべきである。（前ガイドラインの推奨を改訂）</td>
<td>クラスⅠ、エビデンスレベルB</td>
</tr>
<tr>
<td>2. 外科的治療および血管内治療について、合併症発症率を年1回モニターすることが妥当である。（新規推奨）</td>
<td>クラスⅡa、エビデンスレベルB</td>
</tr>
<tr>
<td>3. 脳動脈瘤の治療を担当している医師が適切な教育基準を満たしていることを確認できる病院資格認定制度の制定は妥当である。（新規推奨）</td>
<td>クラスⅡa、エビデンスレベルB</td>
</tr>
</tbody>
</table>

### 表8 外科的治療と血管内治療中の麻酔管理に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 動脈瘤手術中の血圧低下は、程度および時間を最短限に抑えることが適当である。</td>
<td>クラスⅡa、エビデンスレベルB</td>
</tr>
<tr>
<td>2. 一時的な血管閉塞性の薬物による介入および昇圧については、データが不十分で具体的な勧告をすることはできないが、これらを実施することが妥当と考えられる場合がある。</td>
<td>クラスⅡb、エビデンスレベルC</td>
</tr>
<tr>
<td>3. 動脈瘤手術中に低体温を導入することを日常的には勧められないが、特定の症例では適当な選択肢かもしれない。</td>
<td>クラスⅢ、エビデンスレベルB</td>
</tr>
<tr>
<td>4. 動脈瘤手術中は、術中高血糖の予防が有益と考えられる。</td>
<td>クラスⅡa、エビデンスレベルB</td>
</tr>
<tr>
<td>5. 破裂脳動脈瘤の血管内治療中、特定の患者においては全身麻酔の使用が有益と考えられる。</td>
<td>クラスⅡa、エビデンスレベルB</td>
</tr>
</tbody>
</table>
脳動脈瘤によるくも膜下出血の管理に関するガイドライン

表9  aSAH後の脳血管攣縮とDCIの管理に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. すべてのaSAH患者にnimodipineを経口投与すべきである。 (この薬物は、神経学的転帰は改善するが、脳血管攣縮は改善しないことが示されていることに注意しなければならない。) その他のカルシウム拮抗薬の有用性は、現時点では不明である。</td>
<td>クラス I, エビデンスレベル A</td>
</tr>
<tr>
<td>2. DIC予防のために、正常な体液容量と循環血液量の維持が推奨される。 (前ガイドラインの推奨の改訂)</td>
<td>クラス I, エビデンスレベル B</td>
</tr>
<tr>
<td>3. 脳血管造影上に攣縮が発現する前に予防的に循環血液量増加をはかること、またはバルーン血管形成術を実施することとは推奨される。 (新規推奨)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>4. 紅血球ドプラ法、動脈造影発現のモニタリングに妥当な検査法である。 (新規推奨)</td>
<td>クラス IIIa, エビデンスレベル B</td>
</tr>
<tr>
<td>5. CTまたは磁気共鳴画像を用いた灌流画像は、脳虚血に関する脳動脈の検査に有用である。 (新規推奨)</td>
<td>クラス IIIa, エビデンスレベル B</td>
</tr>
<tr>
<td>6. 頭蓋内圧が高い場合、または心肺の状態からの検査が困難である場合、DCIは高血圧の誘発が推奨される。 (前ガイドラインの推奨の改訂)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>7. 臨床性脳血管攣縮の患者、特に高血圧療法に適応した場合においては、脳血管形成術および/または選択的動脈内血管拡張薬療法が妥当である。 (前ガイドラインの推奨の改訂)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
</tbody>
</table>

表10  aSAHに関連した水頭症の管理に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aSAHに関連した急性症候性水頭症は、CSF迂回法（臨床状況に応じてEVDまたは腰椎ドレナージ）によって管理すべきである。 (前ガイドラインの推奨の改訂)</td>
<td>クラス I, エビデンスレベル B</td>
</tr>
<tr>
<td>2. aSAHに関連した慢性症候性水頭症は、恒常的なCSF迂回法によって治療すべきである。 (前ガイドラインの推奨の改訂)</td>
<td>クラス III, エビデンスレベル C</td>
</tr>
<tr>
<td>3. 24時間を超えるEVDからの離脱が、細動脈の治療の必要性を軽減するのに有効とは思われない。 (新規推奨)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>4. 日常的な終板開窓術は、シェント依存性水頭症の発症率の抑制には役立たないと考え、日常的に実施すべきではない。 (新規推奨)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
</tbody>
</table>

表11  aSAHに関連した発病発作の管理に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 出血直後には抗凝固療法の予防的投与を検討してもよい。</td>
<td>クラス IIIb, エビデンスレベル B</td>
</tr>
<tr>
<td>2. 抗凝固療法の日常的な長期投与は勧められず。</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>3. 症状性発作の既往、脳内血腫、偽性高血圧、脳梗塞、中大脳動脈の動脈瘤の発症を防ぐための薬物療法の必要性についての意見は、患者の状態に応じて検討する。</td>
<td>クラス IIIb, エビデンスレベル B</td>
</tr>
</tbody>
</table>

表12  aSAHに関連した内科的合併症の管理に関する推奨

<table>
<thead>
<tr>
<th>推奨</th>
<th>エビデンスの分類とレベル</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. aSAH後の低栄養の大量投与と血管内血液量の減少を防ぐ。</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>2. aSAH発症後の一部の患者では、胃動脈挿入および体液平衡をいくつか組み合わせて血液量の管理をモニタリングすることが、溶血（酵素）またはコロイド液を用いた血液量の減少と同様に効果がある。</td>
<td>クラス IIIa, エビデンスレベル B</td>
</tr>
<tr>
<td>3. aSAHの急性期には、正常血圧を目標とし、標準的または進歩した血圧測定システムを用いて発症を積極的に抑制することが妥当である。 (新規推奨)</td>
<td>クラス IIIa, エビデンスレベル B</td>
</tr>
<tr>
<td>4. aSAH患者の一般的重度治療の一部として、低血糖を厳重に回避し、低血糖の管理を検討してもよい。</td>
<td>クラス IIIb, エビデンスレベル B</td>
</tr>
<tr>
<td>5. 輻射性赤血球の輸血を用いた貧血の治療は、脳虚血のリスクがあるaSAH患者に考慮しても良い。最適なヘモグロビンの目標値は未だ決定されていない。 (新規推奨)</td>
<td>クラス IIIb, エビデンスレベル B</td>
</tr>
<tr>
<td>6. 新鮮ドクストロチゾンと高張食塩液による低ナトリウム血症の予防は無効であると見られる。 (新規推奨)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
<tr>
<td>7. ベンザリン起因性低血糖症を伴う高糖血症を伴うaSAH患者では、低血糖を厳重に回避し、血糖を慎重に管理することを検討してもよい。 (新規推奨)</td>
<td>クラス III, エビデンスレベル B</td>
</tr>
</tbody>
</table>

（文責：柳原 武彦）