XI congresso nazionale

simeu

ROMA 24-26 MAGGIO 2018

Opportunità di esecuzione sistematica di TC cranio con mdc, in caso di sospetta cefalea secondaria

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SC di PS/OBI -AO Brotzu, Presidio San Michele- Cagliari

Ore 00:30 - Donna, 50 anni

Caso clinico

Causa dichiarata all'accettazione: *Cefalea sovraorbitaria bilaterale*

Parametri vitali:
PA: *125/83 mmHG*
FC: *78 bpm*
SpO2: *100% in AA*
TT: *37°C*

Codice di priorità: GIALLO (per dolore)

Caso clinico

ANAMNESI

2 gg fa comparsa, in apparente benessere ed a riposo, di cefalea sovraorbitaria bilaterale. Inizialmente di lieve entità, progressivamente ingravescente nelle ore successive.
Nausea e, in seconda giornata, alcuni episodi di vomito.
Non beneficio con paracetamolo e FANS, autoprescritti.
Ora il dolore è insopportabile.
Nega altri sintomi associati e/o episodi analoghi in passato.
APR muta
TD: pillola EP

OBIETTIVITÀ

Vigile e collaborante, in evidente stato di sofferenza
EO neurologico ndr.

ESAMI EMATOCHIMICI

WBC 12.370 85% NEU, K^+ 3,3 mEq/L

Background

- Cefalea non traumatica

  →2% di tutti gli accessi in PS (range 0,5-4,5%) [1-3]

- Nel 30–55% dei casi sono forme di cefalea primaria (nella metà dei casi emicrania), le restanti sono secondarie (nella maggior parte dei casi "benigne"). [4-8]

- Non semplice identificare le forme primarie in PS, secondo i criteri della International Headache Society (IHS).

  → disomogeneo percorso diagnostico - terapeutico [10–12]

- Trattamento dell'emicrania con evidenza IA [9]:
  - Sumatriptan sc
  - Diidroergotamina im/ev (nd in Italia)
  - Ketolorac im + Antagonisti dopa im/ev

  → Steroidi non efficaci

Caso clinico

Characteristics of headache with serious underlying pathology

History
Explosive onset and severe at onset
No similar headaches in the past
Concomitant infection
Altered mental status
Headache with exertion
Age over 50
Immunosuppression
Physical examination
Neurologic abnormalities
Decreased level of consciousness
Meningismus
Toxic appearance
Papilledema

Evidence-Based Diagnosis of Nontraumatic Headache in the Emergency Department: A Consensus Statement on Four Clinical Scenarios

Pietro Cortelli, MD; Sabina Cevoli, MD; Francesco Nonino, MD; Dante Baronciani, MD; Nicola Magrini, MD; Giuseppe Re, MD; Gianni De Berti, MD; Gian Camillo Manzoni, MD; Pietro Querzani, MD; Alberto Vandelli, MD, on behalf of the Multidisciplinary Group for Nontraumatic Headache in the Emergency Department

Scenario 1

Adult patients admitted to ED for severe headache ("worst headache")

- with acute onset ("thunderclap headache") or
- with focal neurological findings (or non-focal, like a decreased level of consciousness), or
- with vomiting or syncope at the onset of headache.

→

- Head CT must be performed.
- If the result of CT scan is negative, or uncertain, or of poor quality, lumbar puncture (LP) is indicated.
- If LP shows no abnormality, the patient should be evaluated by a neurologist within 24 hours.

Scenario 2

Adult patients admitted to ED for severe headache

- with fever and/or neck stiffness

→

- Head CT and PL must be performed.

Scenario 3

Adult patients admitted to ED for

- headache of recent onset (days or weeks), or
- progressively worsening headache, or persistent headache.

→

- Head CT and
- Routine blood tests, including flogosis indexes (ESR and C-reactive protein) must be performed
- Neurological evaluation should be performed within 7 days if tests are negative.

Scenario 4

Adults with previous history of headache

- complaining of a headache very similar to previous attacks in terms of intensity, duration and associated symptoms.

→

- Evaluation of vital parameters, neurological examination and routine blood tests are indicated.
- If tests are negative the patient may be discharged from ED with indication to her/his general practitioner about the management of primary headaches, and a prescription for a symptomatic headache treatment.
- Referring the patient to a neurological service or to a headache centre for long-term follow-up is recommended.

Caso clinico

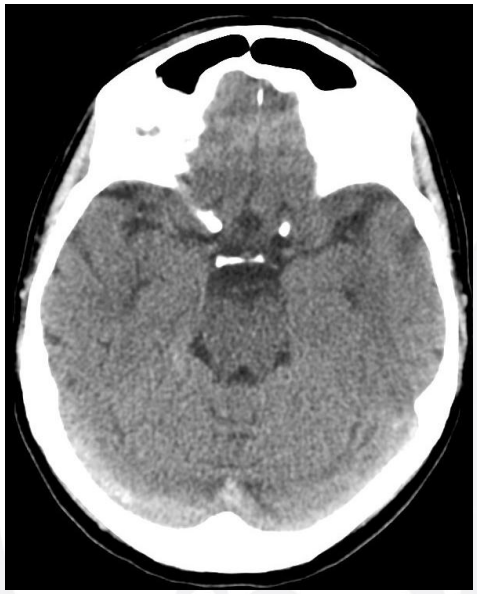
TC SENZA MDC

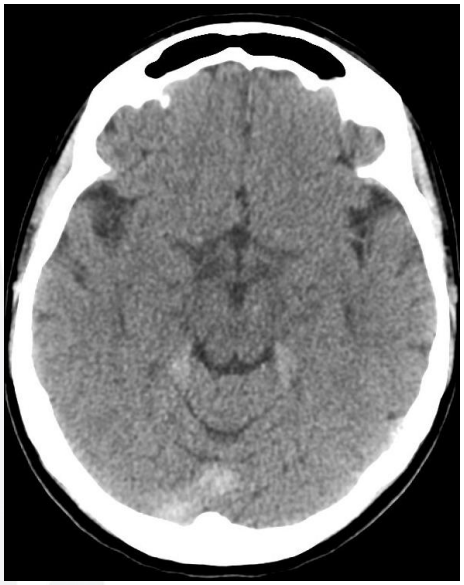
Radiologo in reperibilità

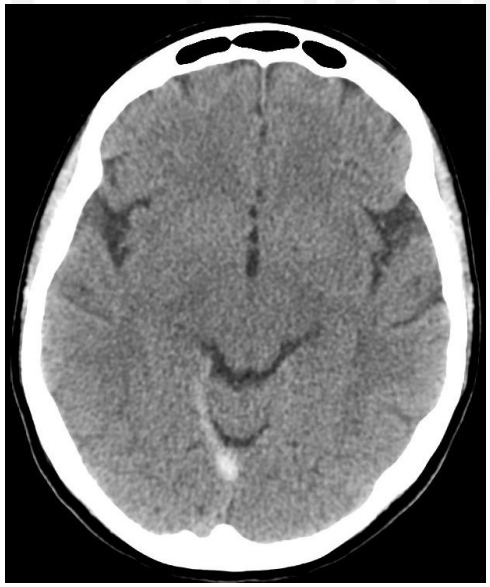
Se TC negativa → stop

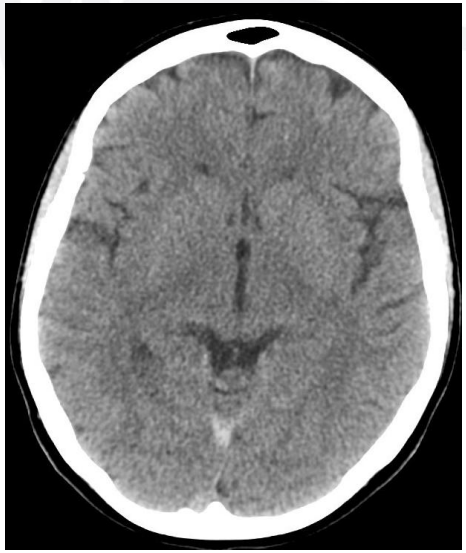
TC SENZA MDC

Caso clinico



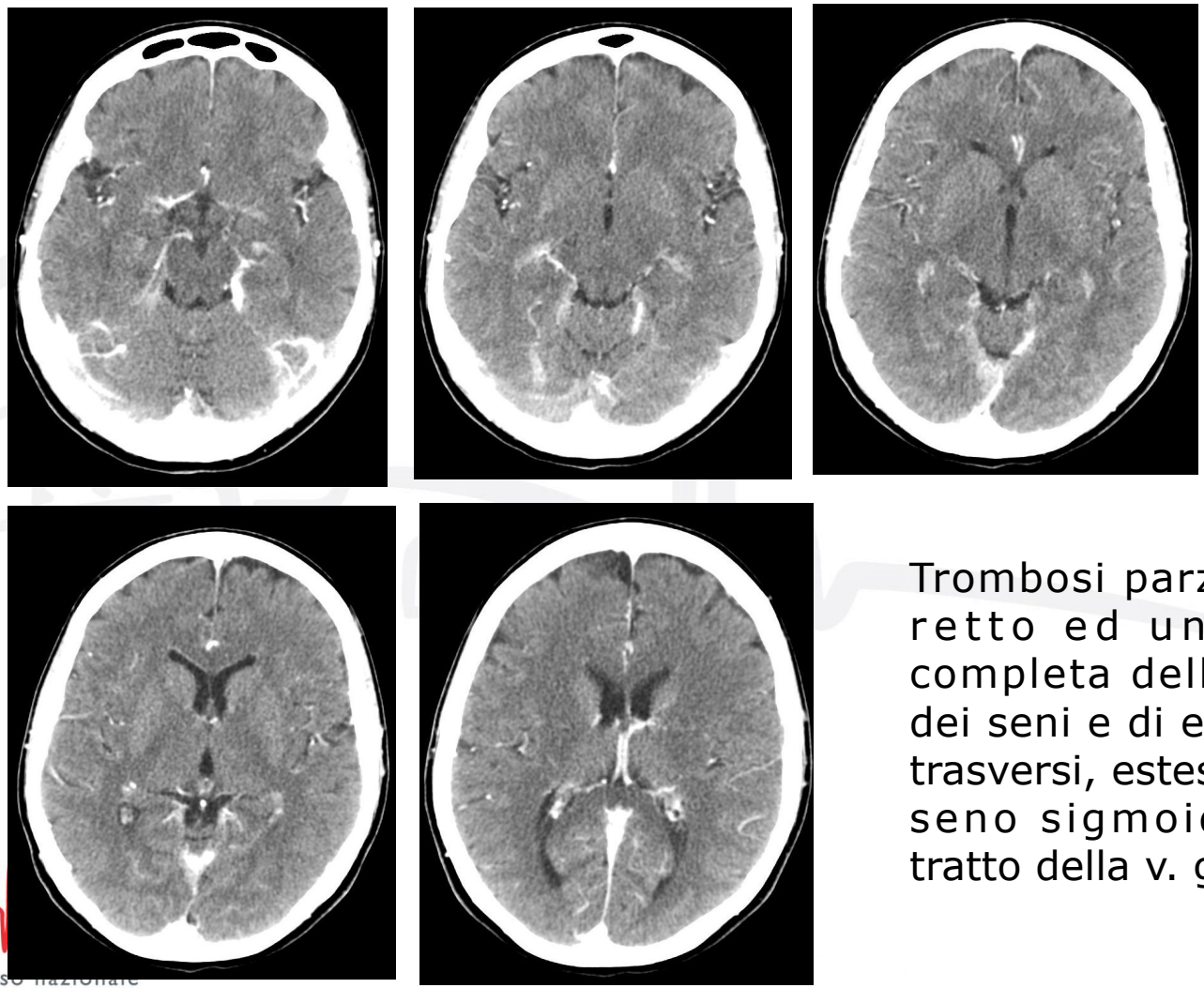




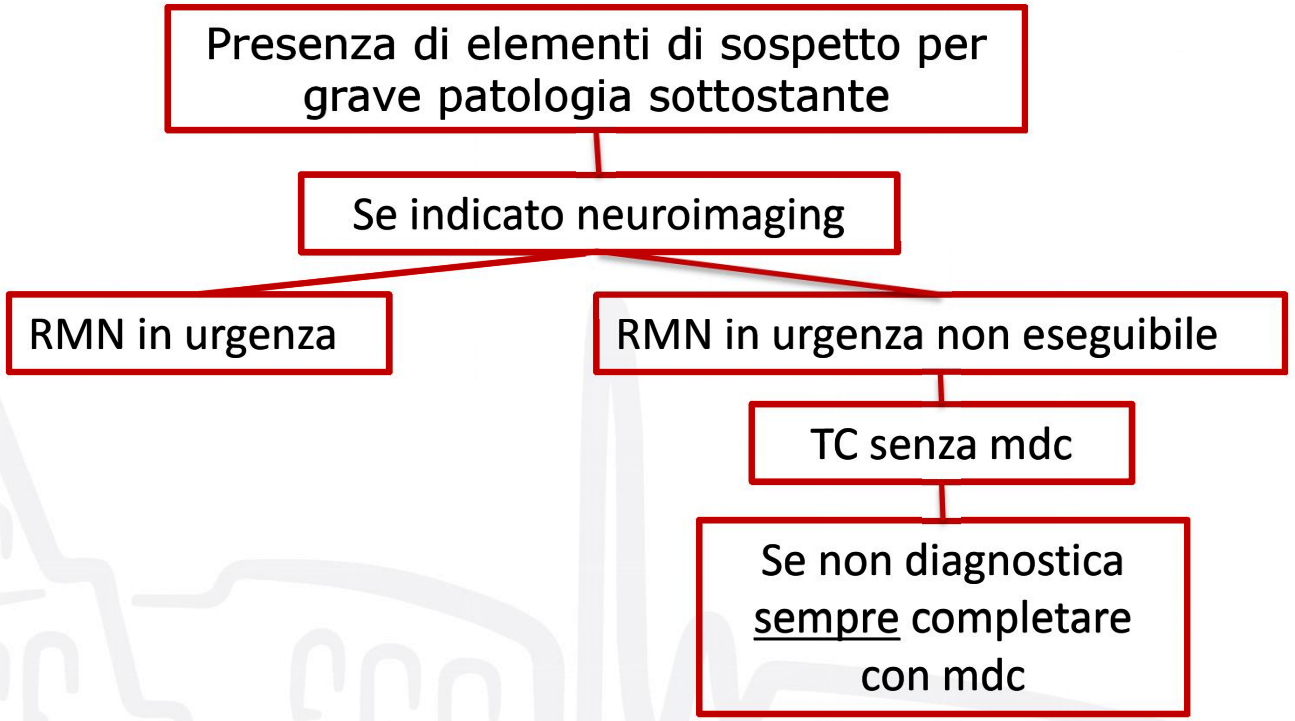


TC CON MDC

Caso clinico



Trombosi parziale del seno retto ed una trombosi completa della confluenza dei seni e di entrambi i seni trasversi, estesa a sinistra al seno sigmoideo fino al I tratto della v. giugulare.



La TC basale, senza mdc, non è dirimente nell'identificazione di forme di cefalea secondarie, come quelle dovute ad alterazioni vascolari cervicali o intracraniche (International Headache Society – ICHD3).

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