



Figure 2 FLAIR hyperintensity in adjacent sulci suggesting subarachnoid haemorrhage.

signs. In these cases, the necessary studies should be conducted to rule out this entity or detect CSF leaks if the diagnosis is confirmed.^{3–6} Further studies are necessary to determine the best treatment for cerebral venous thrombosis in patients with CSF hypotension and increased risk of subdural haematoma.^{6–9} In our case, we decided not to administer anticoagulants since our patient was clinically stable.

Conflicts of interest

The authors have no conflicts of interest to declare.

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Clinical practice guidelines for subarachnoid haemorrhage. Diagnosis and treatment[☆]



Guía de actuación clínica en la hemorragia subaracnoidea. Sistemática diagnóstica y tratamiento

Dear Editor:

We would like to thank the authors for their comments on the clinical management guidelines for subarachnoid haemorrhage. We agree that subarachnoid haemorrhage

should be considered a neurological emergency and managed in the same way as other acute cerebrovascular diseases. Although this type of stroke is less frequent, it affects younger populations and therefore has a significant impact on patients, their families, and society at large. Both stroke and intensive care units are equipped for managing these patients in our setting. Admission by one unit or the other depends on severity: patients with a good level of consciousness (Hunt and Hess grades I and II) are usually admitted to stroke units, whereas patients in poorer clinical condition are managed in intensive care units.¹ We also agree on the need to establish a more precise time frame for early aneurysm treatment; however, due to the lack of randomised studies² and the fact that the studies evaluating this aspect have a retrospective design, it is difficult to determine whether the time frame should be the first 24 or 72 hours.³ Some observational studies suggest that 'ultra-early' treatment (<24 hours) is beneficial for these patients.⁴ The guidelines of the American Heart Association/American Stroke Association recommend treating aneurysms as soon as possible to prevent rebleeding,⁵

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and the guidelines of the European Stroke Organisation recommend treatment within the first 72 hours.⁶

As for vasospasm, numerous studies suggest that delayed cerebral ischaemia may not be due to this complication: some patients have been reported to have vasospasm but not delayed cerebral ischaemia, and vice versa. This is consistent with the paradoxical case of nimodipine, the only drug proven to improve functional prognosis with a level of evidence '1a' and a grade of recommendation 'A'. Nonetheless, it does not reduce the risk of vasospasm.⁷ This may be explained by the fact that delayed cerebral ischaemia is caused by multiple factors, such as microthrombosis, ion alterations, metabolic changes, systemic imbalances, or cortical spreading depression.⁸ Research shows conflicting results regarding the potential benefits of certain agents for preventing this complication. The recently-published STASH trial found no benefits for use of simvastatin.⁹

Subarachnoid haemorrhage is the stroke type most frequently requiring a multidisciplinary approach. We feel that neurologists should play a more active role in the treatment of this entity and care protocols should be more homogeneous among tertiary centres providing care to these patients.

Conflicts of interest

The authors have no conflicts of interest to declare.

Appendix A.

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[◇] Further information about the members of the *ad hoc* committee of the SEN Study Group for Cerebrovascular Diseases is shown in the [Appendix A](#).