

# HEMORRHAGIC STROKE

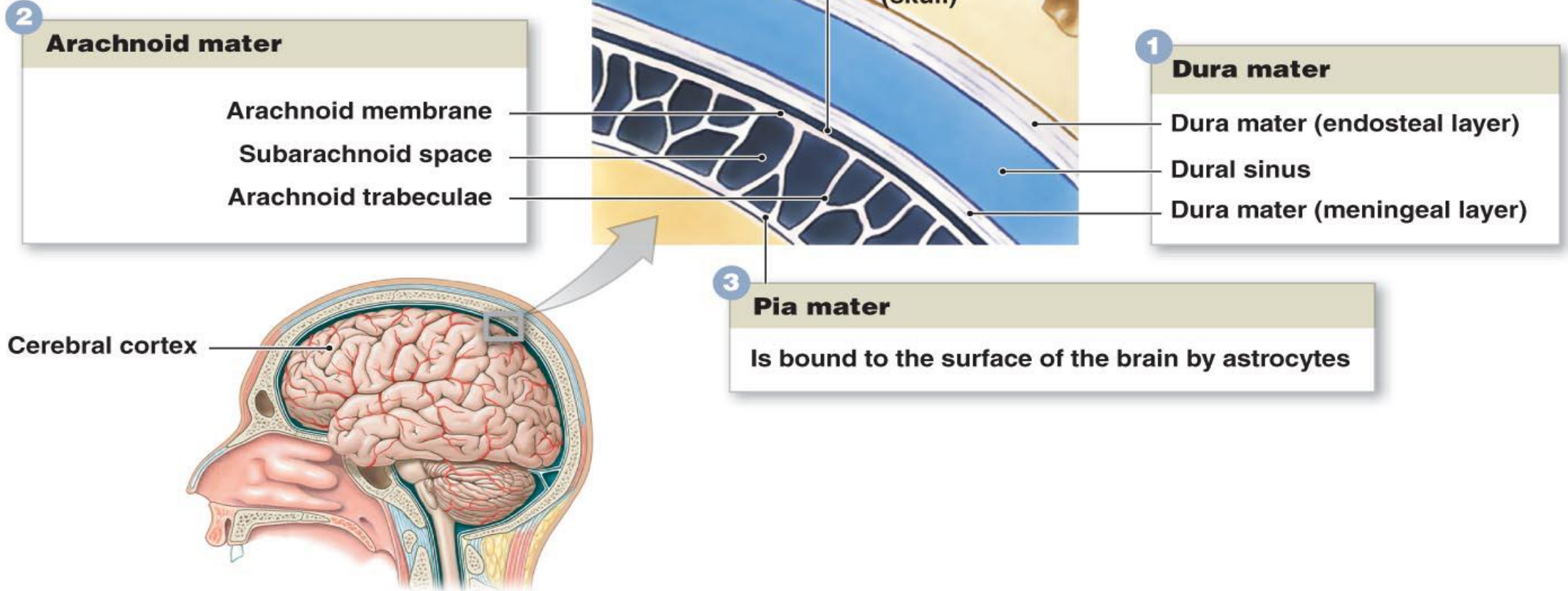


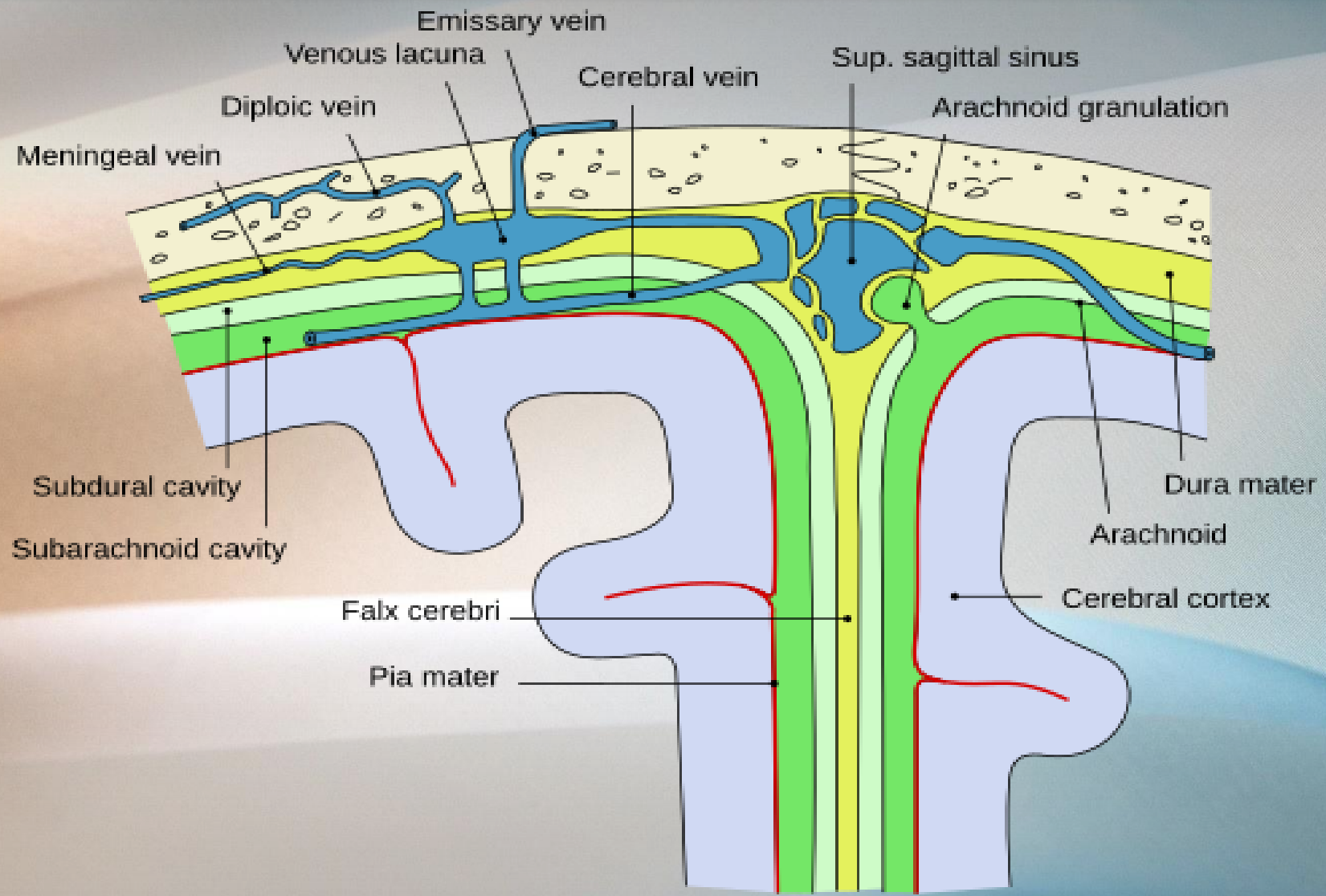
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**13 % OF STROKE CASES  
INTRACEREBRAL OR EXTRACEREBRAL  
(SUBARACHNOID/EPIDURAL, SUBDURAL)**

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The three layers of the cranial meninges:  
the dura mater, arachnoid mater, and pia mater





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**MIDDLE MENINGEAL ARTERY  
EMBOLIZATION TO TREAT  
CHRONIC SUBDURAL HEMATOMA**

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# CHRONIC VS ACUTE SUBDURAL HEMATOMA

THESE ARE COMPLETELY DIFFERENT DISEASE PROCESSES.

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**ACUTE SDH IS CREATED BY TRAUMA & TEARING OF BRIDGING VEINS.  
IMMEDIATE MASS EFFECT OCCURS.  
VERY HIGH MORTALITY RATE.**

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**CHRONIC SDH IS IN THE ELDERLY.  
IT IS CHARACTERIZED BY REPETITIVE MICROBLEEDS AND FLUID EXUDATION  
FROM INFLAMMATORY NEOVASCULAR MEMBRANES.  
AVERAGE AGE OF PATIENT IS LATE 70'S.**

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**CHRONIC SDH IS NOT OFTEN ACUTELY FATAL  
BUT HAS SIGNIFICANT MORBIDITY AND DISABILITY.**

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**HISTORICAL TREATMENT IS SURGICAL EVACUATION,  
BUT RECURRENT RATE IS HIGH  
(20%)**

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**THE BLOOD SUPPLY TO SUBDURAL SPACE IS MIDDLE MENGEAL  
ARTERY WITH NERVE INTERVATION FROM 5<sup>TH</sup> NERVE.**

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WITHIN THE LAST DECADE BETTER UNDERSTANDING OF THE DISEASE OF CSDH HAS EMERGED. THIS IS NOT A DISEASE OF VENOUS OOZING. TRAUMA IMITATES THE FORMATION OF INFLAMMATORY NEOVASCULAR MEMBRANES DUE TO DAMAGE TO DURAL BORDER CELLS. THIS LEADS TO INFLAMMATION OF PROANGIOGENIC CELLS. THESE CELLS CREATE NEOVASCULAR MEMBRANES THAT OOZE AND BLEED.

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**MMA EMBOLIZATION HAS THUS  
COME TO THE FOREFRONT OF  
CHRONIC SDH TREATMENT.**

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**MULTIPLE STUDIES SHOW NOT ONLY  
NONINFERORITY BUT ACTUAL IMPROVED  
OUTCOMES WITH EQUAL IN-HOSPITAL  
COMPLICATION RATES.**

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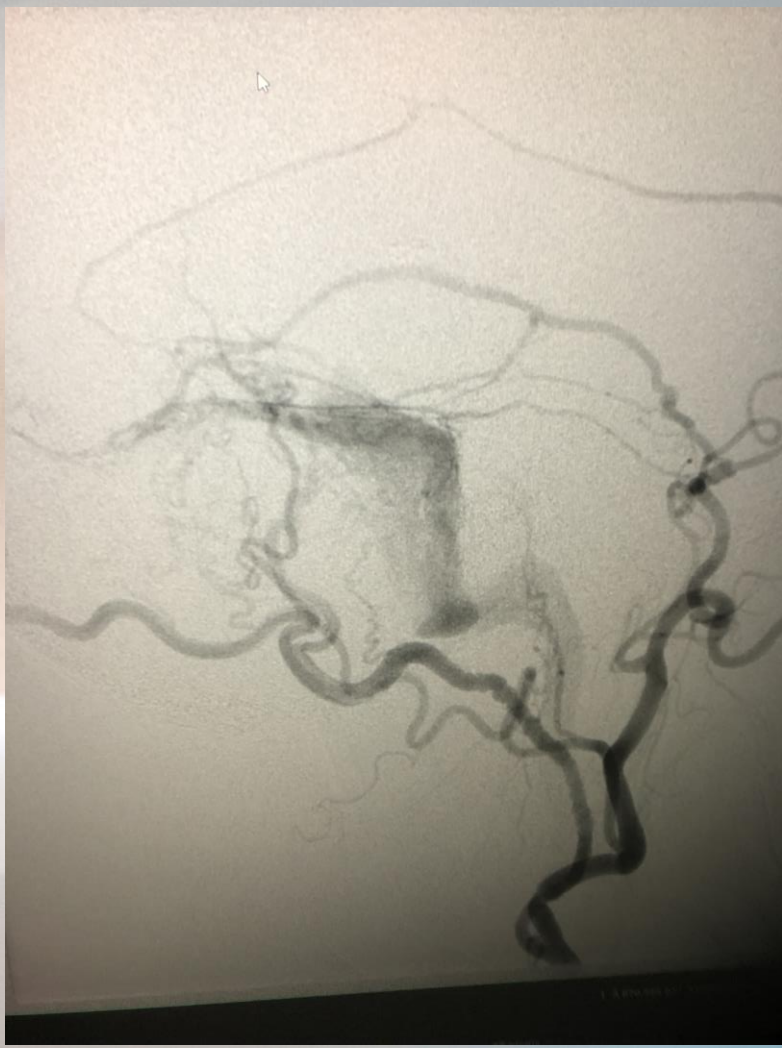






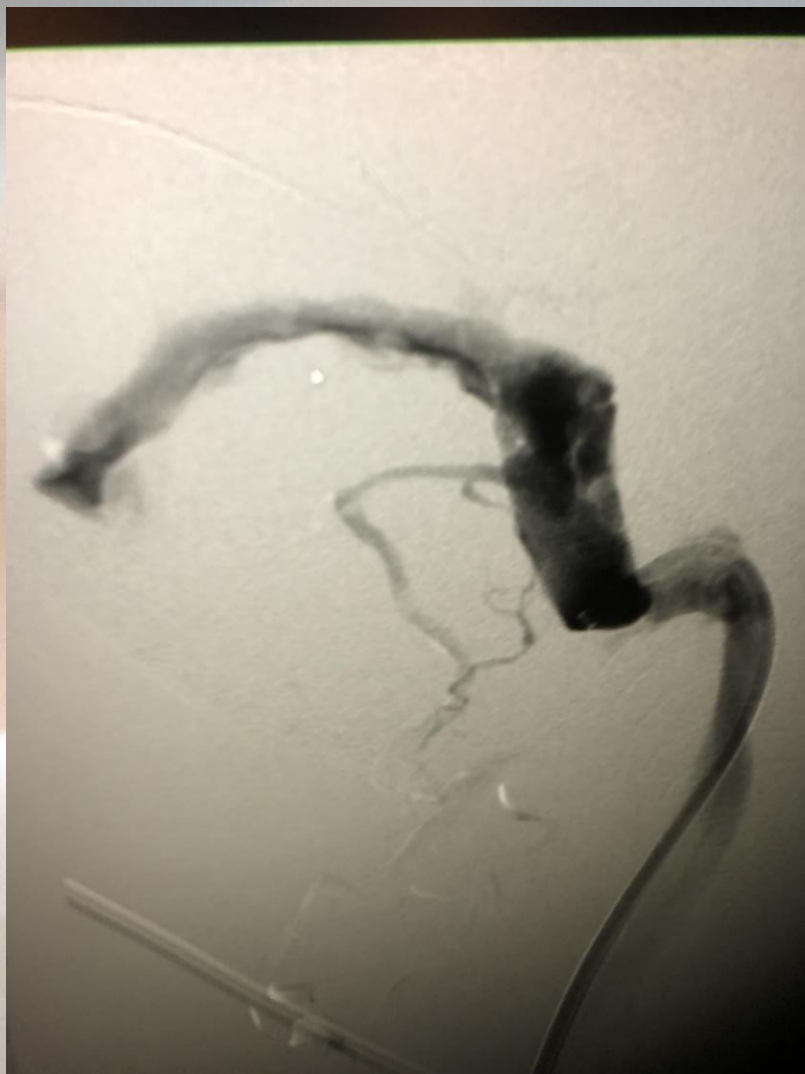


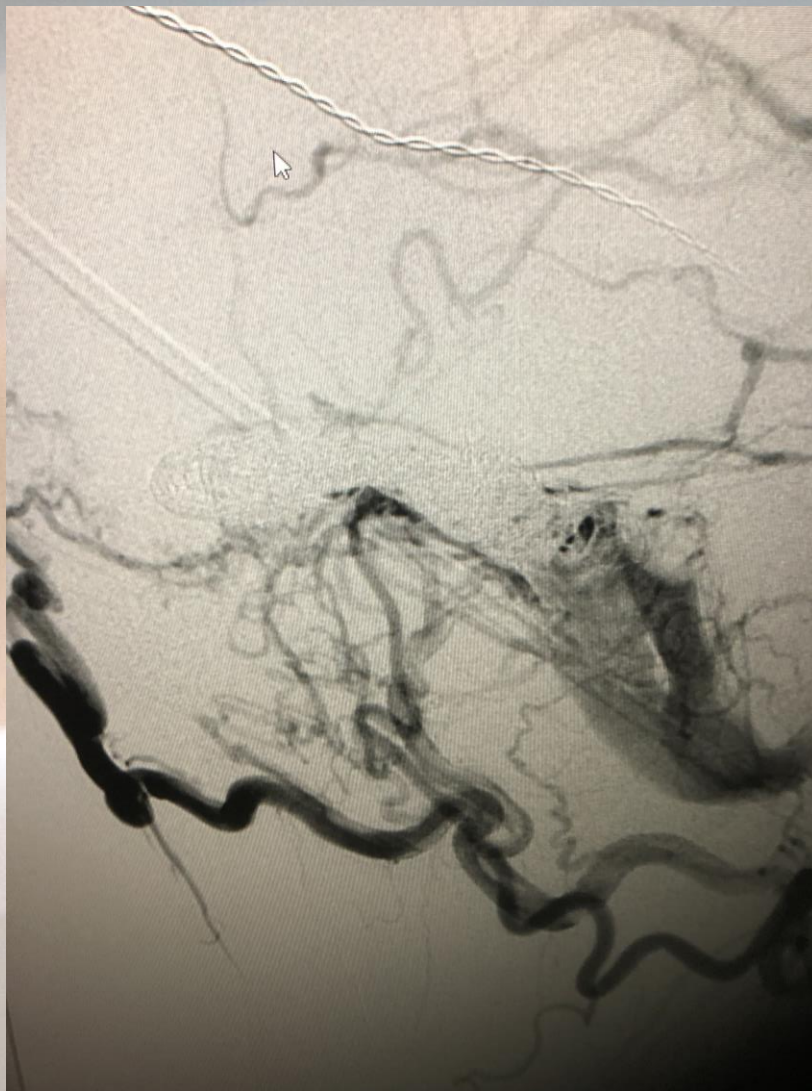








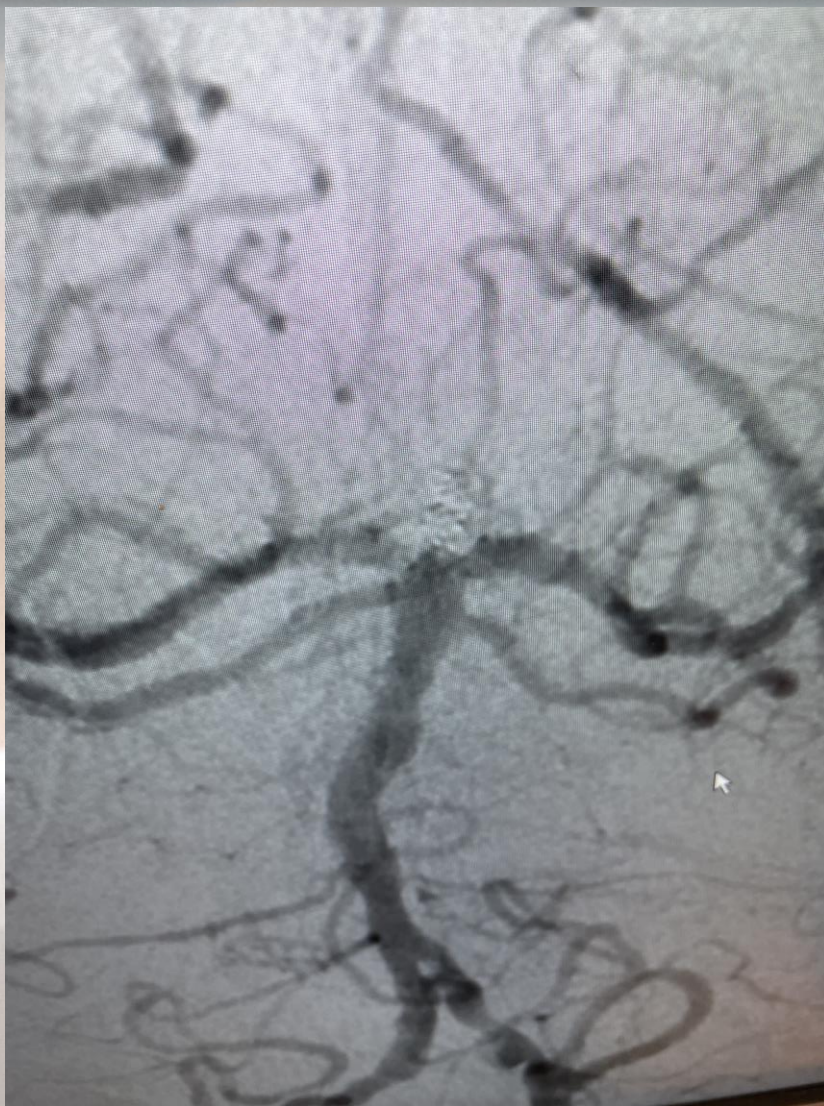


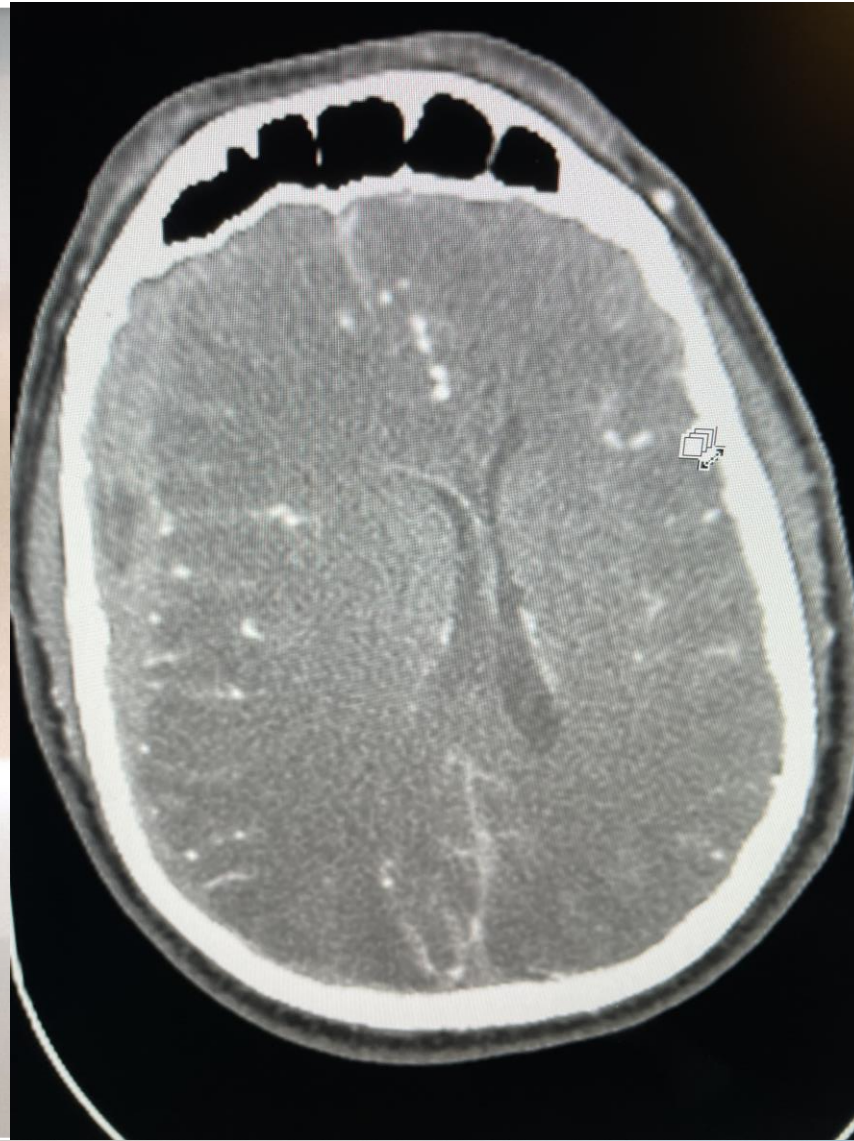


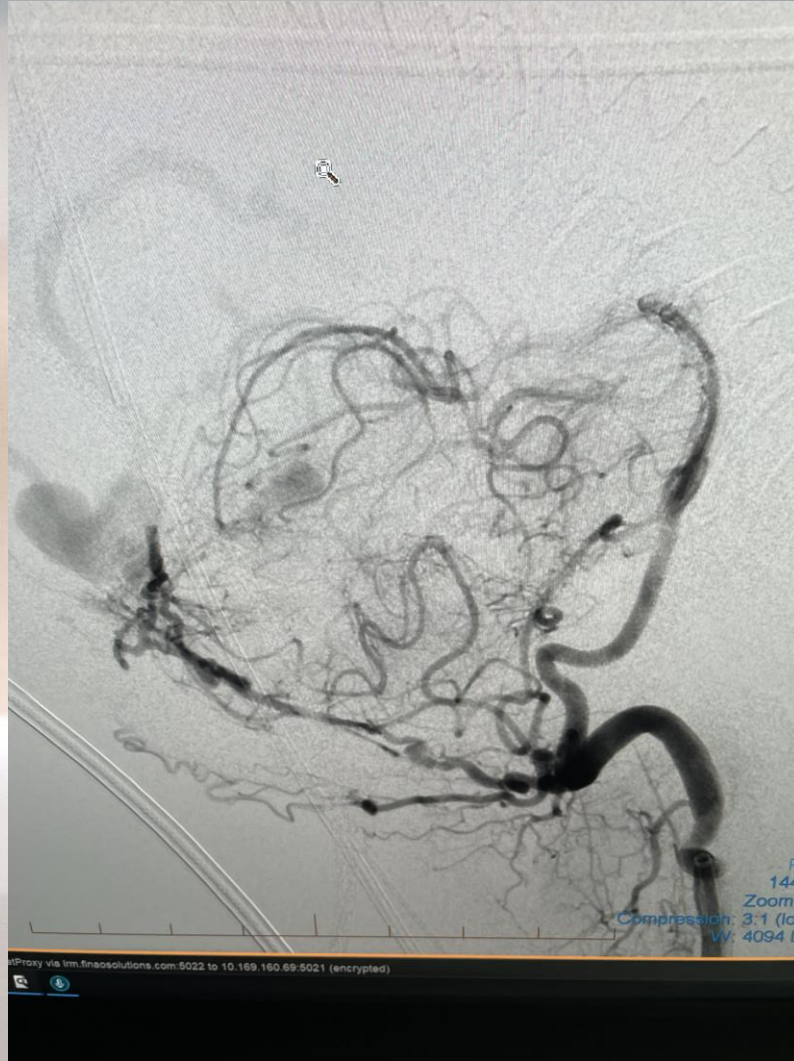




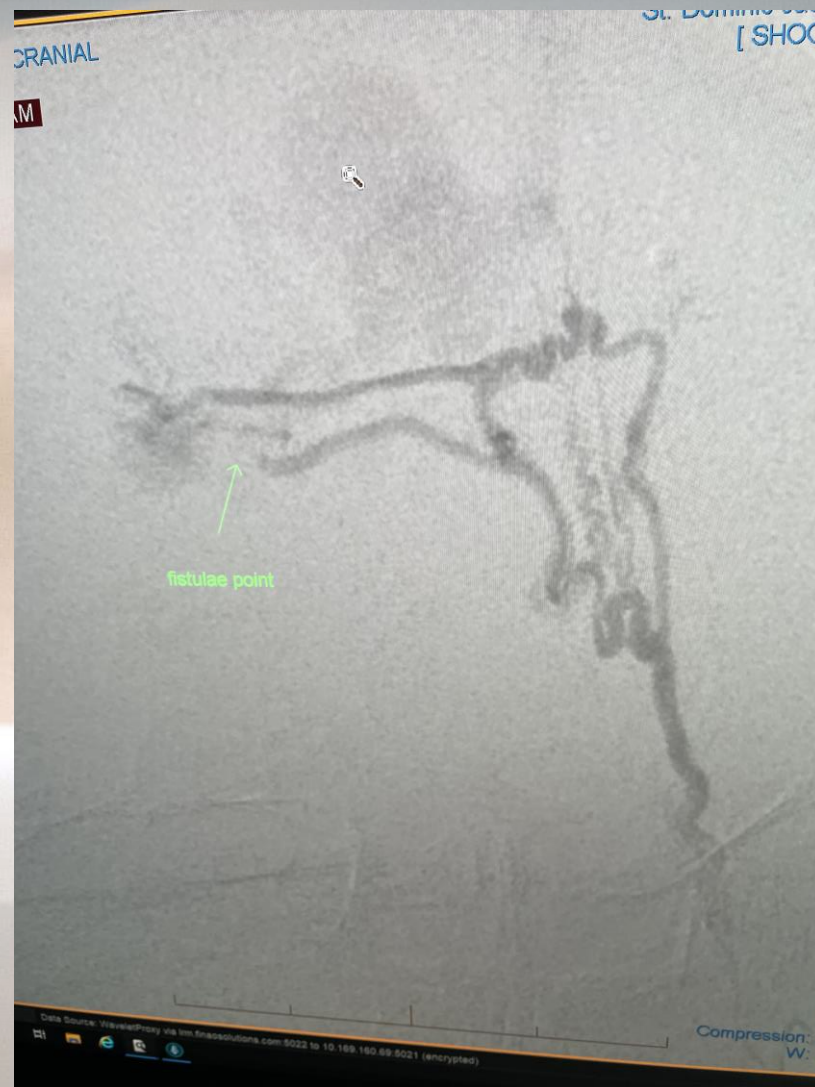


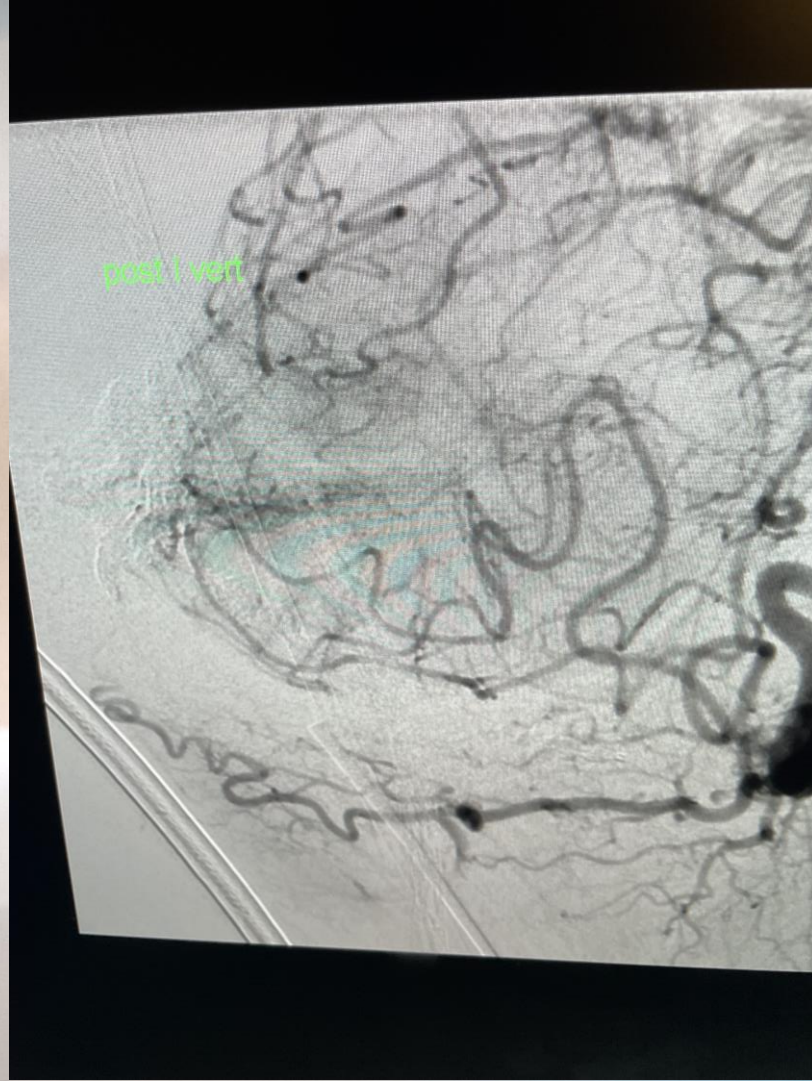




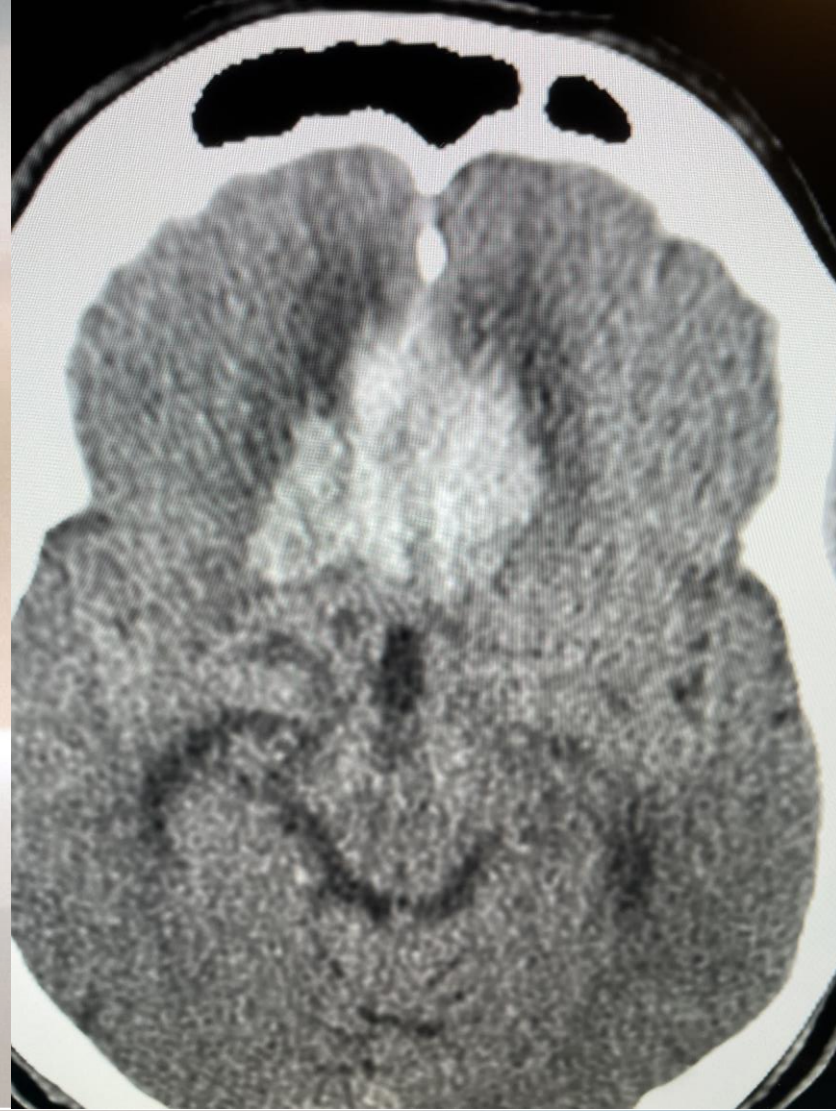


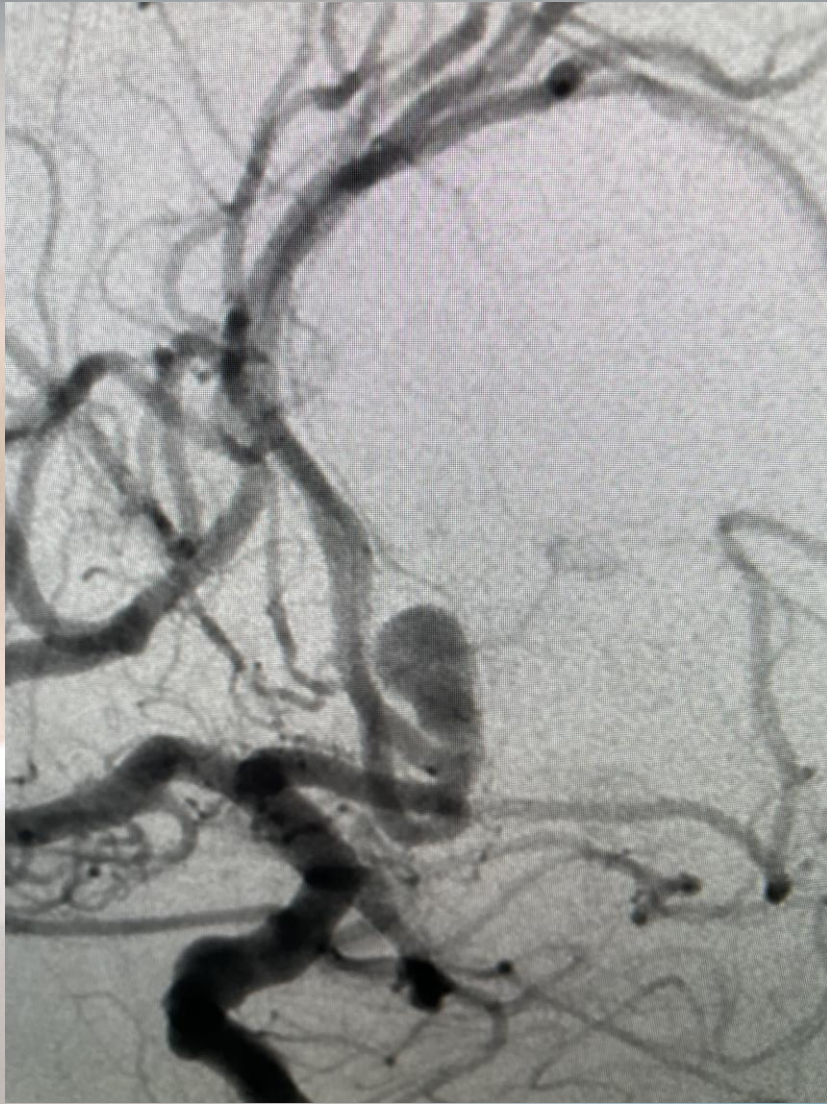


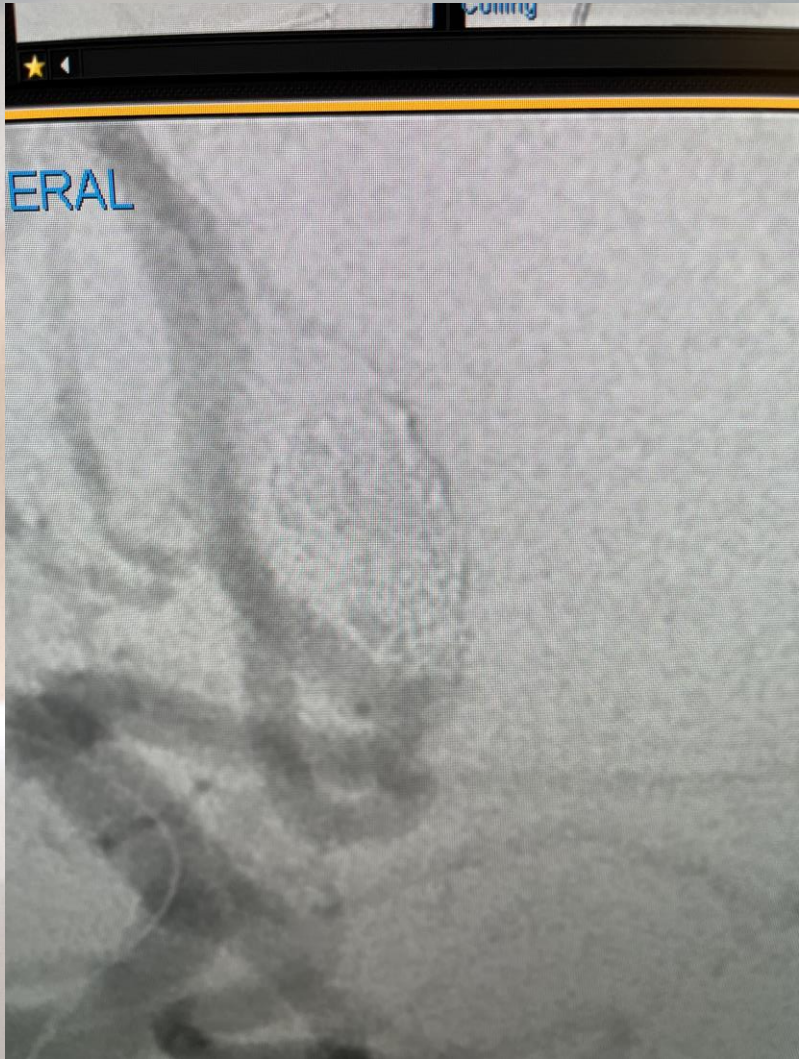






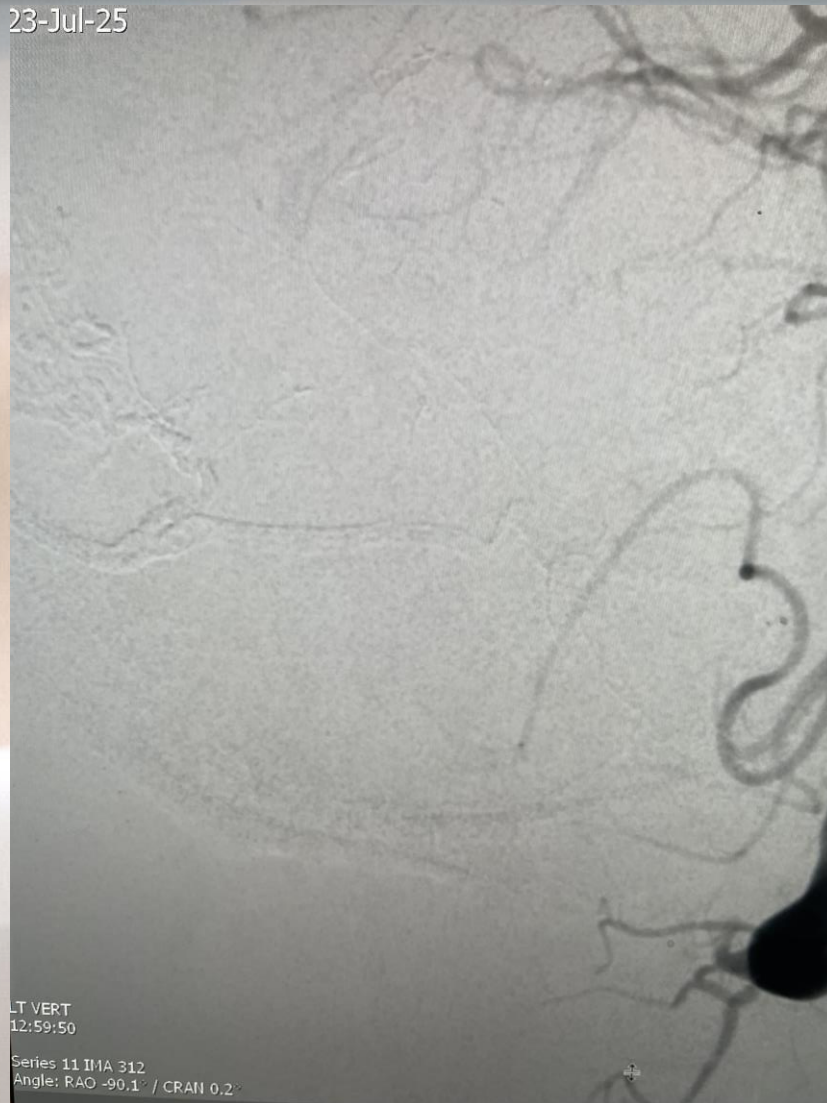








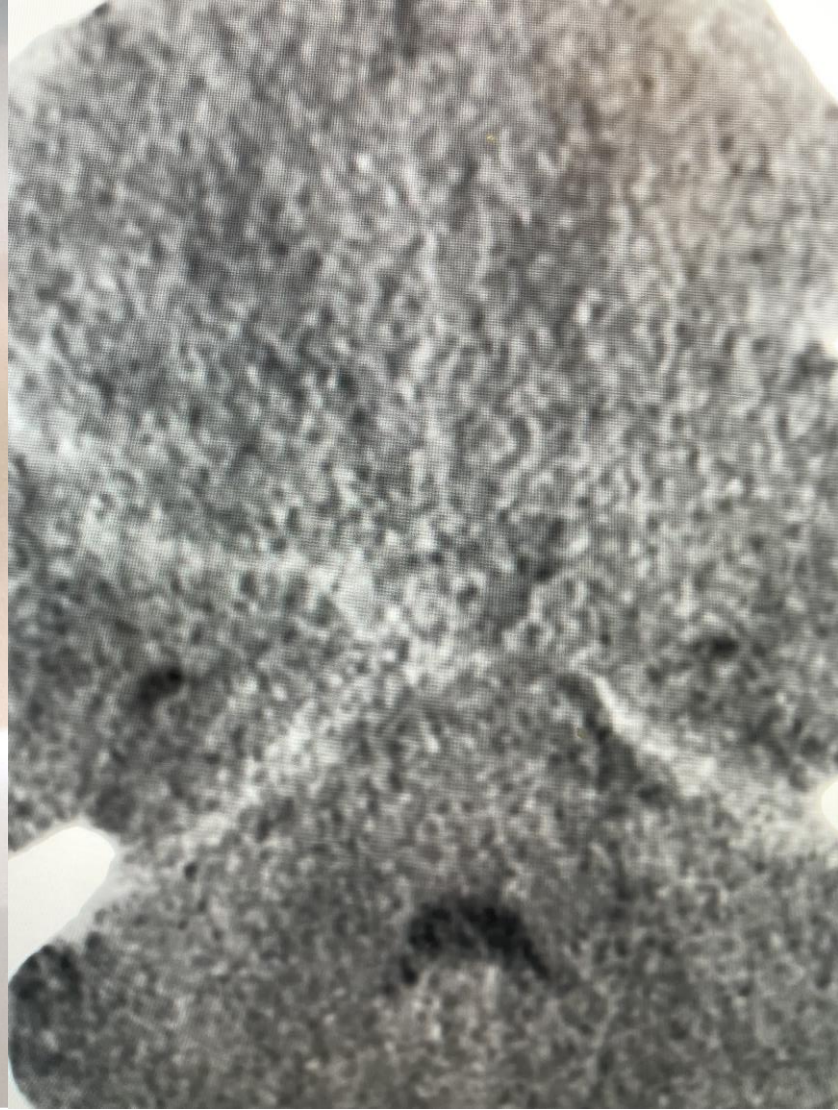
23-Jul-25



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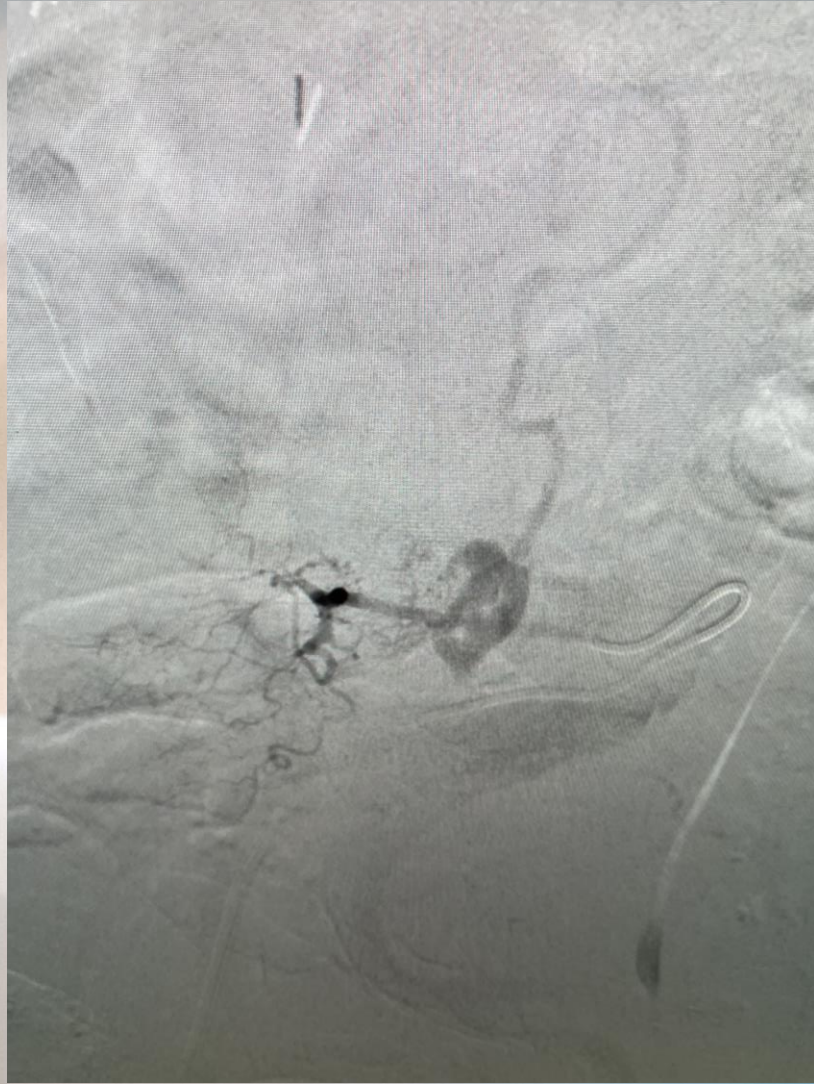


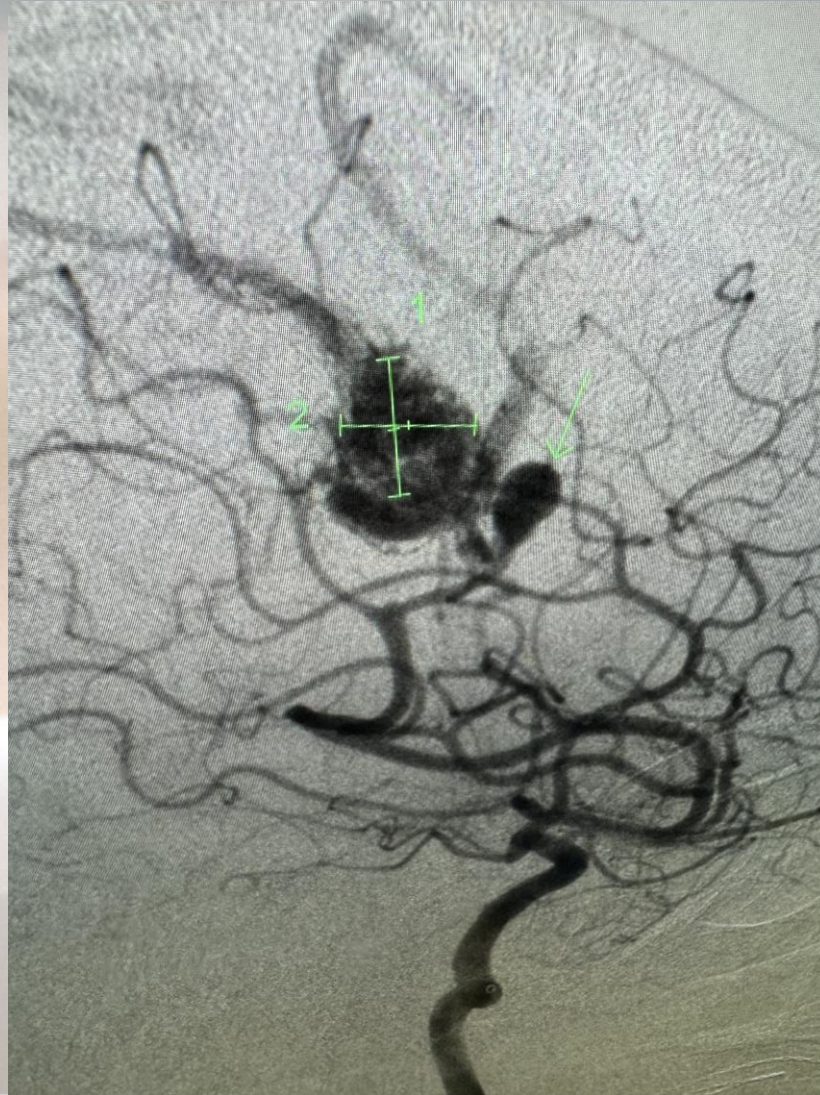












RANIAL BILATERAL

