

Case Report

A Rare Case of Bilateral Spontaneous Intracerebral Haemorrhage Presenting With Left Hemiplegia: A Case Report

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Abstract

Haemorrhage is responsible for around 11% of stroke syndrome. Haemorrhage usually occurs at a single site. However, it can be at multiple sites in some specific conditions i.e. coagulopathy, vascular malformation, malignancy etc. A 56-year-old male with left sided hemiplegia was admitted in the rehabilitation ward of RIMS, Imphal. He was hypertensive and was on irregular medication for that. He was also an alcoholic and chronic smoker for last 20 years. Patient was conscious and clinical examination revealed left 7th and 12th cranial nerve involvement with left hemiplegia. Non-contrast CT scan of brain revealed right thalamus and left basal ganglia haemorrhages. Thorough history and investigations did not reveal any aetiology for bilateral haemorrhage. Patient was treated with conservative management and improvement was noticed in serial follow-ups. There are very few case reports about bilateral spontaneous intracerebral haemorrhage associated with other diseases like migraine, Japanese encephalitis etc. Cause of bilateral haemorrhage in our case is doubtful.

Key words: Intracerebral haemorrhage, stroke syndrome, cranial nerve.

Introduction:

Stroke is one of the commonly encountered diseases in rehabilitation ward. Prevalence of stroke is increasing day by day due to rise in elderly population. Infarction and haemorrhage due to vascular cause are responsible for stroke syndrome. Out of these two, spontaneous haemorrhage is responsible for around 11% cases¹. Putamen is the most common site for spontaneous intracerebral haemorrhage followed by

thalamus¹. Among the haemorrhagic strokes, 10% spontaneous haemorrhage occurs in the cerebellum¹.

Bilateral spontaneous intracerebral haemorrhage is rare in hypertensive patients but can occur in association with other aetiologies. Prognoses of such cases are also poor.² However, in our case, no specific aetiology was identified and improvement of the condition was noticed over time.

Case Report:

A 56-year-old male was admitted in the rehabilitation ward with complaint of sudden onset of weakness of left upper and lower limbs. Patient was a known hypertensive patient for last 10 years and was on irregular medication. He was also an alcoholic and chronic smoker for last 20 years. There was no history of any chronic medication, bleeding disorder or any other significant health problem in the past. Clinical examination revealed left 7th and 12th cranial nerves involvement with normal higher mental function and speech. Left upper limb was found to be flaccid. Left lower limb also shows poor motor control with grade 2 motor power in hip flexors according to Medical Research Council scale. Deep tendon reflexes were found within normal limits along with extensor plantar response on affected side. Ankle clonus was present on the left side and sensory response

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was intact on both sides. Blood pressure was 200/120 mm Hg on admission but became normal following medication within few days.

All routine investigations were found to be normal except low HDL level in lipid profile picture. Non-contrast CT scan of brain showed right thalamus and left basal ganglia haemorrhage (Fig1). There was no past history of any abnormal health condition. We investigated the coagulation profile, which was also found to be within normal limits.

Patient was treated conservatively and improvement was noticed during serial follow-ups.

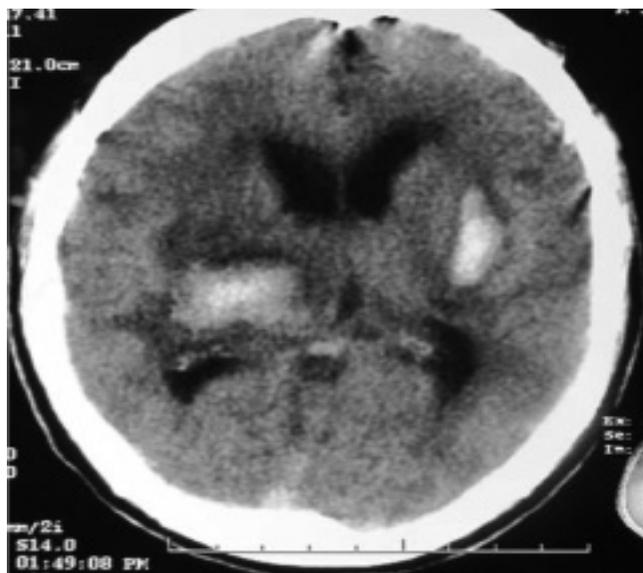
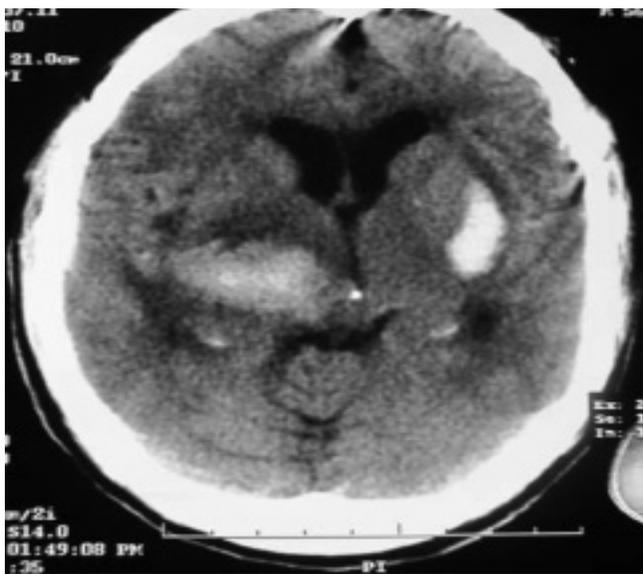


Fig 1: NCCT Brain Shows Bilateral Cerebral Haemorrhage

Discussion:

Stroke is defined as sudden onset of persisting focal neurological deficit of vascular origin¹. Other causes of focal neurological deficit i.e. brain tumour, abscess, trauma, seizure, etc, are not included in stroke and they form the differential diagnosis of stroke.¹ Risk factors of stroke can be divided into modifiable and non-modifiable ones¹. Identification of modifiable risk factors are very important as prevention of these factors can prevent stroke and its recurrence. The common modifiable risk factors are hypertension, heart diseases (valvular, arrhythmia etc), smoking, diabetes mellitus, hyperfibrinogenaemia, hyperlipidaemia etc³. Among these risk factors, hypertension is the most common aetiology for spontaneous intracerebral haemorrhage⁴. Simultaneous intracerebral haemorrhage can occur in opposite side of brain but bilateral spontaneous intracerebral haemorrhage is a rare phenomenon and few case reports mentioned some association other than hypertension. These are coagulopathy, vasculitis, infection, methanol intoxication, diabetic keto-acidosis, migraine etc³. Prognosis of such cases were also found bad even in smaller size haemorrhages². Actual pathophysiology leading to bilateral spontaneous intracerebral haemorrhage is not well known. There are two opinions, one is rupture of microaneurysms bilaterally, formed as a result of chronic hypertension and the second one is simultaneous haemorrhage to opposite brain following first haemorrhage⁴. In our case, we could not find any association. Patient was hypertensive for 10 years and on irregular antihypertensive medication. Therefore, it can be because of rupture microaneurysm formed because of chronic hypertension.

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