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神经系统急症

Neurologic and Neurosurgical Emergencies

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Harcourt Asia
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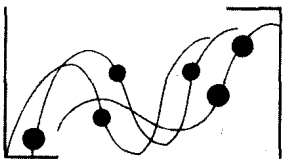
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Neurologic and Neurosurgical Emergencies

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This book is dedicated to my father
***Julio Adamor Cruz** (in memoriam),*
for his daily demonstrations on the value of hard work and humanitarian help to human beings;

and to my Neurosurgical Instructor
***Vittorio Rolando Boccaletti, M.D.** (in memoriam),*
for his superb teaching of Neurosurgery and Humanitarian Medicine
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Preface

The International Society for Neuroemergencies (ISONEUREM) was founded with the aim of converging nonsurgical (neurologic) and neurosurgical emergencies into a single body of scientific information, heavily based on clinical experience (without extrapolation from animal experimentation). The first ISONEUREM symposium (NEUROEMERGENCY '96), held in July 1996 in Freeport, Bahamas, was a very friendly, unbiased, and productive event, where all neuroemergency professionals could exchange clinically relevant information from the initial event through the emergency room and all phases of hospitalization, up to neurorehabilitation.

This book represents an original effort to concentrate in a single volume the roots of ISONEUREM, namely, to address unbiased, updated information regarding adult and pediatric neuroemergency issues in a most comprehensive fashion.

Up until now, the term *neuroemergency* has not yet been defined in medical dictionaries. According to the ISONEUREM standards, however, neuroemergency issues are expected to be covered in a combined and multidisciplinary fashion, rather than in isolated islands of pertinent medical information.

At the second ISONEUREM symposium (NEUROEMERGENCY '99), to be held in Italy, the above-described philosophy will be further enhanced, and all future ISONEUREM events will highlight the merit of addressing unbiased, strongly scientific and clinically relevant information on the diagnosis, pathophysiology, and management of acute insults to the nervous system.

It is therefore believed that this book will provide the reader with truly useful information on this rather complex topic, beyond previously published books or journal papers addressing questionable information regarding neurologic and neurosurgical emergencies, and neuro intensive care medicine.

JULIO CRUZ, M.D., PH.D.

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Incentive and support are frankly appreciated from my family members in the cities of Rio de Janeiro, São Paulo, and Guarujá, in Brazil.

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Pre-graduate medical educational support from my teachers at Curso Objetivo in the city of São Paulo, Brazil, is also frankly appreciated.

Graduate medical teaching is also strongly appreciated from my professors at Faculdade de Medicina do ABC, in Santo André, São Paulo, Brazil.

Following medical graduation, I strongly acknowledge the support of my neurosurgical professors at Escola Paulista de Medicina, Federal University of São Paulo, São Paulo, Brazil, and the University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, USA.

As a faculty member, I heavily thank the physicians, nurses, scientists, and technicians from the University of Texas Medical School at Houston, Texas, USA, the University of Pennsylvania Medical Center, Philadelphia, Pennsylvania, USA, and the Allegheny University of the Health Sciences, Philadelphia, Pennsylvania, USA.

My 1980–81 experience as a Post-Graduate Fellowship Award recipient, sponsored by The Rotary Foundation of Rotary International, was rather gratifying and unforgettable.

JULIO CRUZ, M.D., PH.D.

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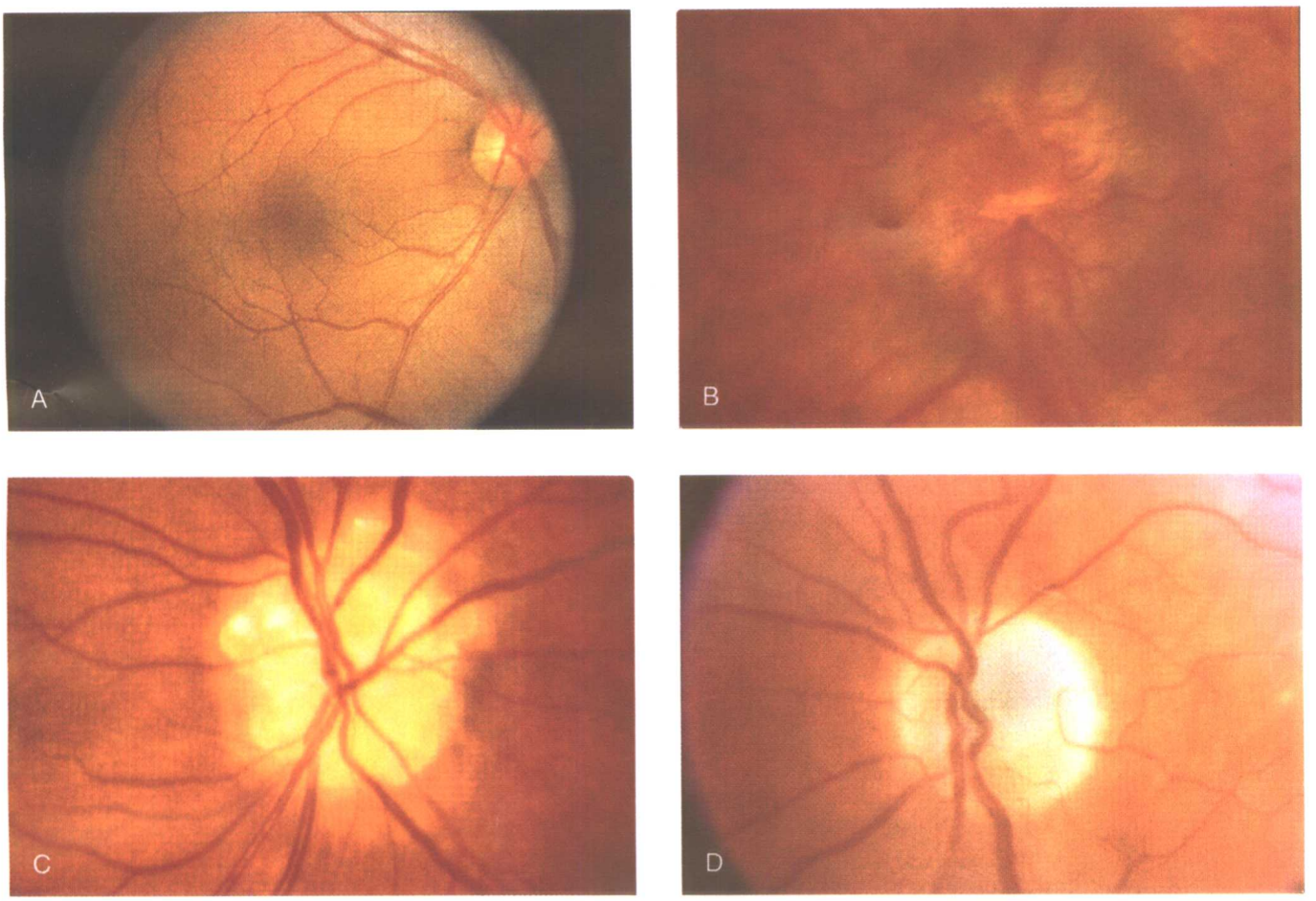


FIGURE 7-1 • *A*, Normal optic disc. *B*, Fully developed papilledema, demonstrating disc swelling, hyperemia, venous distention, and hemorrhages. *C*, Disc drusen (pseudopapilledema): note central origination of vessels and absence of peripapillary nerve fiber layer swelling. *D*, Segmental atrophy secondary to anterior ischemic optic neuropathy.

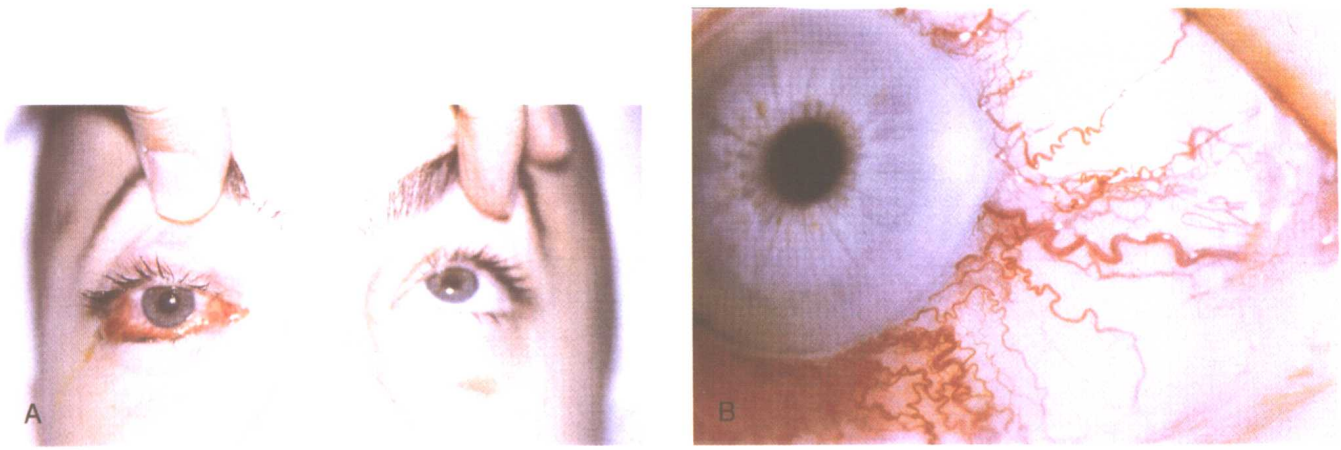


FIGURE 7-6 • *A*, Arterialized conjunctival and scleral vessels, exophthalmos, and chemosis due to orbital congestion from carotid-cavernous fistula. Impaired eye elevation may be from muscle and nerve dysfunction. *B*, Close up of arterialized conjunctival vessels.

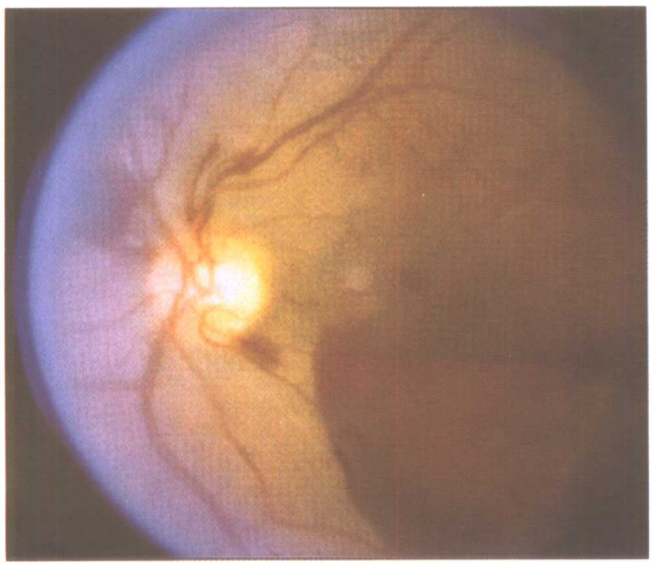


FIGURE 7-8 • Terson's syndrome: subhyaloid "boat-shaped" hemorrhage secondary to rupture of anterior communicating artery aneurysm.

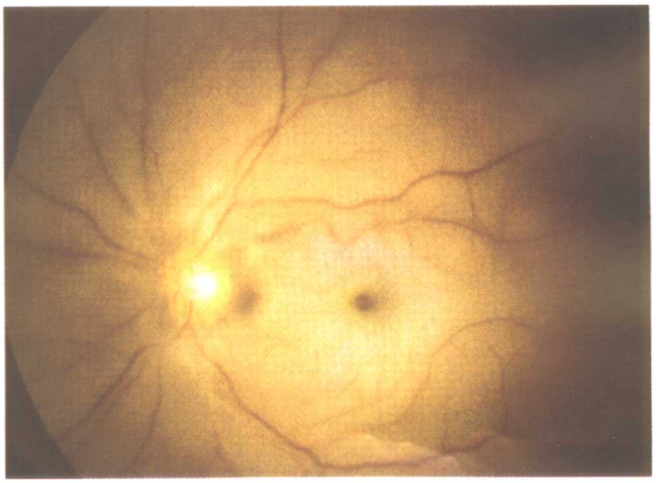
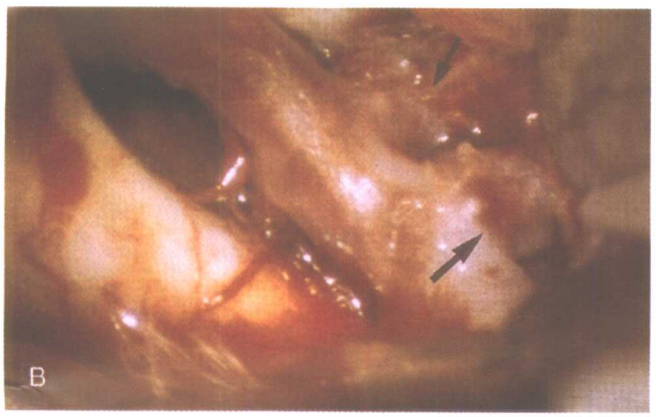


FIGURE 7-9 • Central retinal artery occlusion. Note pale retina, with attenuation of vessels.



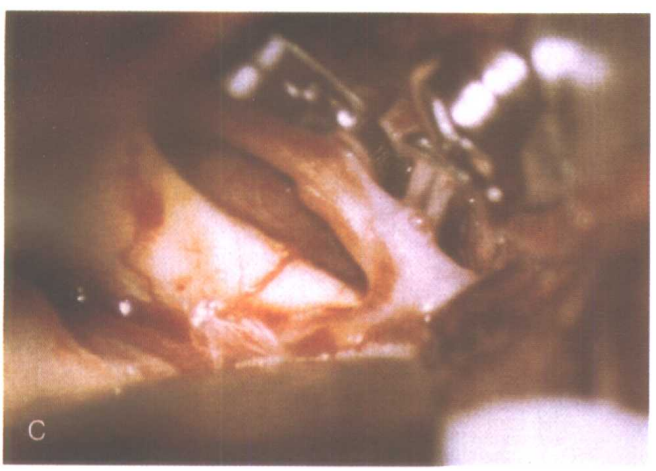


FIGURE 10-16 • *B*, Intraoperative photomicrograph showing both aneurysms (PComA aneurysm—small arrow; AChA aneurysm—large arrow). *C*, Following clip obliteration of both aneurysms.

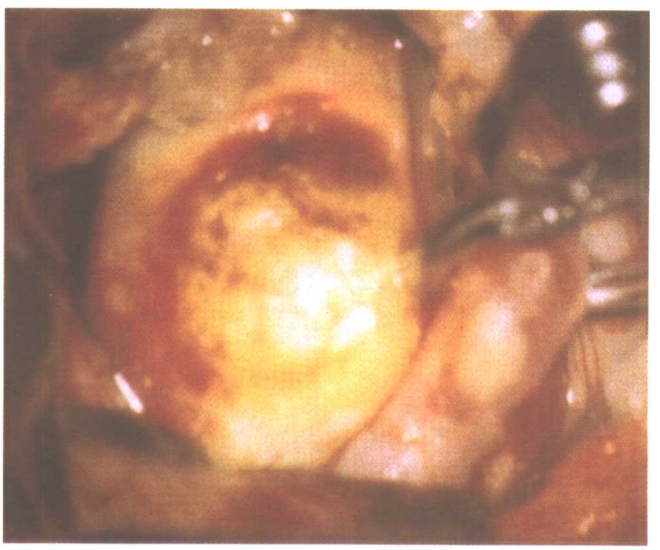


FIGURE 10-30*B* • Intraoperative photomicrograph showing the heavily calcified, atherosclerotic aneurysm dome, which was repaired with an angled fenestrated clip.



FIGURE 13–1 • Patient with acquired myasthenia gravis, revealing characteristic snarl upon attempting to smile.



FIGURE 13–2 • Bilateral facial paralysis in Guillain-Barré syndrome. The patient is attempting to close both eyes. Note impossibility of upper lid closure with bilateral Bell's sign. Bilateral facial drooping is also noted, most evident on the right.

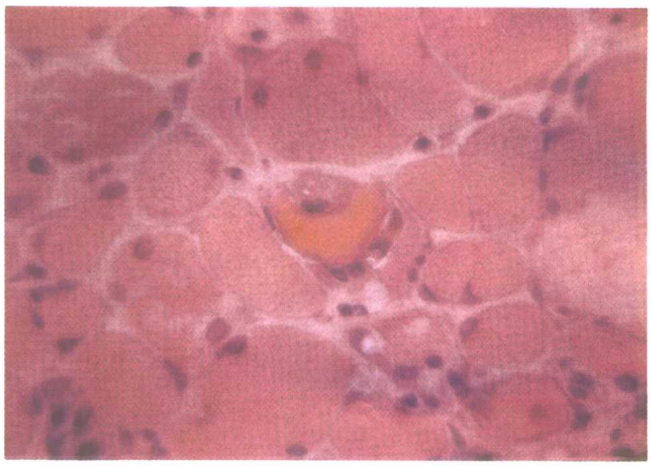


FIGURE 13–5 • Acute alcoholic myopathy. Widespread segmental necrosis of muscle fibers, eosinophilic alteration of sarcoplasm (center of photograph), phagocytosis, and regeneration (H&E × 120).

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