

A Study of Outcome of Decompressive Craniectomy in Acute Massive Cerebrovascular Accidents

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Abstract

Males had higher preponderance among all the stroke patients. In the infarct group 71.42% were males where in females were females were 28.57% with male–female ratio of 2.5 :1. 73.33% were males, whereas females were 26.67% in hemorrhagic group. Hypertension was the most common risk factor comprising of 64% in decompressed group and 70% in non decompressed group. This was followed by alcoholism with 62% in decompressed group and 36.67% in non decompressed group. Craniopatriæxostotomy is used often for cerebellar flow-related edema and expands space more often when there is still a reasonable volume of fluid across the brain to most patients, helping with functional outcomes. The clinical performance is enhanced for patients who make certain, individual decisions and get their procedures done as early as early as possible after stroke. Rehabilitation is also is needed and can be permanent, and in some cases, so judgments on the quality of life of participants, so an understanding of how each group is doing is essential. Malignant Stroke was most common in 5 th and 6th decade (44%). Diabetes was prevalent in 44% of decompressed patients and in 46.67% of non-decompressed group. Smoking and cardiac diseases were the other prominent risk factors. Young strokes secondary to vasculitis were less but showed prevalence of 2%.68.18% of patients in ischaemic group who underwent decompression had involvement of dominant lobe and 71.43% in hemorrhagic group had dominant lobe involvement.

Keywords: stroke, cerebrovascular, Hypertension, Neuroimaging, craniectomy, haemorrhage and cerebral artery

1. Introduction

an illness of people. It occurs where the part of the brain's blood supply to the arteries is interrupted or where the brain's arteries are blocked due to arteriosclerosis, the most prevalent neurological disorders (CNS). in developing nations, Europe and North America, it is the third leading

cause of death after cardiovascular disease and cancer According to World Health Organization data, the number of people having a stroke per 1,000 per 100,000 is around 179 around the world. In the West, the prevalence of mental illnesses is 794 out of 1,000 in the population.0% According to this study of India's communities of more than one million people over the age of one hundred and fifty and fifty years old, the blunt stroke rate for the population was 545 per 100, for every 100,000 individuals, or roughly 1 million cases. It was determined that the ratio of males to females was around 1.7 Astrocytic vascular abnormality or stroke is capable of inducing debilitating illness in both young and elderly people. They may also have social, psychological, and economical effects as well as well as social and economic results. Society's curiosity in Cerebrovascular-mediated injuries have since they're common and expensive both in terms of money and life because of the number of people they've hurt. More important than any other risk factor in the development of illnesses or diseases is social or environmental injustice.

It ischemic stroke represents 85% of all strokes and ischemic patients have a 10% risk of death due to hemorrhage; here ischemic patients are the exception to the reverse.

immobilized marine organisms need to be able to spread to fill a lot of room before they die. signs of death, the threat of Cerebral deaths, if not cerebral hemorrhage, occurs about 2 and 5 percent and 53 percent with the chances of mortality being between 89 percent to 89 percent, and the reality is that in one to more than 2, she would have CAB, and the reality is that she would have either have had CAB or died from cerebral hemorrhage 2 - 3 days after When 2 to 5 people are all listening to the same book at the same time, it's called a group. However, as stroke death was over 90%, these occurrences were classified as "malignant cerebrovascular accidents" [1] diseases to discuss the rapidly developing deadly cerebral swelling. are most often caused by a blockage or tear in the carotid artery, the M1 part of the middle cerebral, or the PCA. However, neuroimaging criteria vary from author to author. as diffusion-weighted magnetic resonance imaging (MRIs) to be seen; extension of the arterial infarct zone to more than 45%; additional hemorrhagic changes seen on diffusion images at; diffusion-weighted magnetic resonance imaging (DWI) or infarcts seen on scan more than 145 cm³; other parts of the basal ganglia are shend."

According to many findings, surgery to decrease the amount of brain edema and increase survival is called hemicraniectomy as applied to patients with hemi- or stellate brain-related infarcts. In this series, we have calculated that of the 80 patients treated, 50 received a craniectomy while the other 30 were treated with medical management.

2. MATERIALS AND METHODS

Study design

We present the findings of hemispheric infarctions, particularly those above the neck size of 3 cm, as well as the size of the enlarged cerebral vascular

trunk vessels following a decompressive craniotomy from August 2013 to December 2015. A large cerebral infarction, MCA and PCA with at least 2/3 (which accounts for more than two thirds of the total territories involved), plus space-occupying and white-brain territory(leading to ACA or PCA) as a contributing factor to the final CT finding of cerebral territory occupying over 50% of the MR images, must be considered. The Barthel Index (formal test of organ function), Modified Rankin Scale (functional test after discharge), and Gender Completion Scale (older and younger female), and National Institutes of Health Stroke (feasibility of Movement Assessment) evaluations, on their admission and after six months, were provided to patients to assess the post-hospital recovery. There was a monitoring group of 30 people who did not have surgery because of a denial of consent, who who had the time not entered the hospital in a timely manner as yet when the procedure was started These subsequent research studies were also applied to patients with favorable and unfavorable outcomes to measure the differences between their respective effects.

Medical management

Standard protocols to control blood pressure and anti edema measures were started on arrival followed by addition of antiepileptics and assessment of patient status on basis of 4 scales –NIHSS, GCS, BARTHEL INDEX and MRC

Surgical technique

A standard frontotemporo parietal decompressive craniotomy was performed on the affected side. If the CVA was haemorrhagic, clots were evacuated .

Patient selection

Inclusion Criteria

condition, meaning the imaging and the CTs saw those with a significant midline vascular event detected such an enormous fluid build-up in the brain, so that a resection of the area behind the cranium was performed. patients with Glasgow Coma Scale of consciousness (GCS) >13, score at the time of admission to the intensive care unit (ICS), NIH scale 14-18, and a lack of significant change in the signs, or base on middle concussions who were given in the ICS initial treatment were held in the ICU. The indications that supported the cerebellar decompressive craniectomy surgery included neurological impairment or the initiation of herniation in the brain such patients with initial Glasgow Coma Scale (GCS) <8, NIWA scale (NIWADCWA) score of ≥ 30 , Glasgow Coma Scale (GCS <30, NII) and cistern change on computed tomography (midline shift) were transferred for craniotomy The patients with GCS, Barthel Index, MRC, NIHSS Score in between these scores showed worsening to the scores of decompression group prior to the selected time period of 24 hours. The control group of patients presenting later than 24 hrs with signs of severe cerebral herniation signs and respiratory depression were not taken up for surgery as per evaluation by both neurologist and neurosurgeon.

They were managed medically with artificial ventilation,

osmotherapy, and other supportive management. The patients in both groups were taken up for tracheostomy as per need by 10th day.

Exclusion Criteria

Late presentations low scores non consent for operation were deferred operation as described above . Other major considerations were

- BLOOD DISORDERS / COAGULOPATHY
- CONTRAINDICATION FOR ANAESTHESIA
- PREGNANCY
- OTHER BRAIN RELATED DISEASES
- B/L PUPILS DILATED AND FIXED
- GCS <4
- PRE STROKE MODIFIED RANKIN SCALE ≥ 2

Tools used:

1. National Institutes of Health Stroke Scale ¹⁴

A instrument, or assessment tool, called the NIH Stroke Scale measures the extent of the harm caused by a stroke, which provides a way to judge the ability of patients to perform daily activities. Each of the 11 NIH-Stanford scale items has a scale ranging from 0 to 4, with respect to its item specific ability. For each aspect of a person's performance, a particular disability (scores 0) signify whether it is natural or whether that person or not (some degree of impairment is present). Each of the different scorers sums from the scores from the items gets added together to form a patient's NIHSS total. At the upper end of the scale, the maximum potential range, the maximum possible score is 42; and at the bottom, the minimum possible is 0. modified Rankin Scale, Rankin Scale of 17

Using the adapted Rankin Scale (a widely used variant of the RSC) is a good technique for calculating the amount of time that people with disabilities spend in activities each day.

"A stroke or other kinds of neurological damage can result in paralysis." In this age of big pharmaceutical trials, it has been the most often used result in clinical trials. increasing the inter-observer agreement of the mRS can be accomplished by using a standardized questionnaire during the interview process The [growth] responsiveness score is widely criticized for being subjectively biased, this method distorting outcomes, but it is a standard measure used in the hospital and outpatient programs to determine the need for continued recovery. have simpler formal interviews to allow the patient and the opportunity to comment on things, and also have less intrusive ones to see whether the patient has the capacity to discuss more complicated issues 11 a measure of general health in which total growth has been set as an annual goal of children who have not achieved specific goals

the quality of performance of life scale established in World Health Organization's five categories: mobility, self-care, personal care, dressing and oral hygiene, usual living, Activities of Everyday Living (ADL) as an ordinal scale within the WHO's five dimensions: mobility, personal care, dressing, and oral hygiene, daily living, and hygiene, and usual activities (ADL). Every performer is scored on this scale, which gives him or her a certain number of points to that serves as a ranking, whether for an event or a result. It is based on ten variables that describe ADL and mobility. If you have recovered from the hospital stay, the higher your amount of self-reliance would allow you to stay in your own home and feel more independent than when you begin treatment. an essential component of the evaluation of and piece of work and which object, which is based on how much time and energy it takes to complete. the raw score is influenced by all factors except for those those which exist only within the context of the actual test, and everything outside of the test's question, including environmental variables Participants' score would drop if their own environments are not expanded. If a study looks to make some possible environmental adjustments, so include these, they should be referenced and listed in the Barthel index.

a score of 10 to 11 on the Glasgow Coma Scale indicates a severe injury to the brain, and one greater on the Coma Scale from 1 to 11 denotes a substantial injury

original and extended (for many hours) clinical examination by standardizing the presentation of [providing a uniform and objective (for several hours) GCS) determination as well as characterizing it for use in both a () standard and practical () exams. Sometimes, and under the strict standards, the patient scores between 3 (indicating full unconsciousness) and 15 (on the expanded scale). The physician grades the patient on the clinical test, and this yields either an index score of 14 or 15 (either completely unconscious or following the stricter standards). The patient's clinical score results return to consciousness is graded by a clinical scale, which has the two-scoring model (the more widely used modified or revised scale).

3. Results

80 patients (58 males and 22 females) with mean age 50 ± 12 , presenting with acute massive cerebrovascular accidents were collected from, prospective analysis spanning 3 years (August 2013-August 2015). In this group 50 patients underwent decompressive craniectomy and remaining 30 patients were managed conservatively (table 1 & 2). 21 of 30 patients who were treated conservatively had late presentations with signs of severe cerebral herniation suggesting poor outcome on assessment by neurologist and neurosurgeon; and 9 of 30 patients refused consent for surgery. 50 patients (mean age 50 ± 12) underwent decompressive craniectomy with GCS < 8 , Barthel index ≤ 5 , MRC ≤ 5 , NIHSS Score ≥ 30 and cistern compression or midline shift at CT scan.

Risk Factors	Decompression Group n-50 (62.5%)	Non Decompressed Group n-30 (37.5%)
DIABETES MELLITUS	22(44.0%)	14(46.7%)
SYSTEMIC HYPERTENSION	32(64.0%)	21(70.0%)
CARDIAC DISEASE	11(22.0%)	6(20.0%)
OTHERS (VASCULITIS)	1(2.0%)	0(0.0%)
SMOKING	21(42.2%)	9(30.0%)
ALCOHOLISM	31(62.0%)	11(36.7%)

With reference to previous studies patients were taken up for surgery within the first 24 hours of presentation after assessing the neurological and cardiac status. The patients showed improvement to $GCS \leq 8$ Barthel Index ≤ 10 MRC ≤ 4 and NIHSS Score ≥ 22 in post op stage; $GCS \leq 10$ Barthel Index ≤ 30 MRC ≤ 4 and NIHSS Score ≥ 20 at time of discharge and $GCS \leq 12$ Barthel Index ≤ 50 MRC ≤ 3 and NIHSS Score ≥ 14 at 3 months and $GCS \leq 12$ Barthel Index ≤ 65 MRC ≤ 3 and NIHSS Score ≥ 10 at 6 months follow up. Of the 50 patients with massive infarction 1 patient had massive venous stroke. 22 patients in the ischaemic group underwent decompressive craniectomy; and in these 15 patients had involvement of dominant lobe. In the haemorrhagic group 28 of 50 patients were taken up for surgery and in this 20 had dominant lobe involvement. The involvement of dominant lobe did not show any significance with reference to improvement. Of the remaining 30 patients 13 patients had ischaemic stroke and 17 had hemorrhagic stroke and they were not taken up for surgery due to reasons mentioned earlier (table 2). All patients were given antioedema measures and adequate ventilation in addition to other necessary supportive measures. 1 patient who underwent successful decompressive craniectomy expired due to secondary cause - aspiration pneumonia. In the group where decompressive craniectomy was deferred no patients survived. (Table 3).

The mean stay in ICU for patients who underwent decompressive craniectomy was 14 ± 4 days, and the total hospital stay spanned to 24 ± 5 days due to early intervention within first 24 hours. Secondary causes of death in patients who underwent decompressive craniectomy were assessed

and it showed major factor of death as aspiration pneumonia(1 cases).Aspiration pneumonia was identified as significant contributor to mortality in this study following a successful procedure, this patient who died did not receive early tracheostomy within the first 10 days. The assessment of the study showed majority of the patients who received early tracheostomy (22 ischaemic and 27haemorrhagic) showed better outcome as tracheal toileting and reduction of anatomical dead space contributed to better perfusion of lung (table 4).

Table 1. Age sex distribution of patients presenting with acute massive cerebrovascular accidents

AGE	MALE	FEMALE	TOTAL	PERCENTAGE %
21-30	3	1	4	5
31-40	5	1	6	7.5
41-50	10	4	14	17.5
51-60	24	11	35	43.75
61-70	13	4	17	21.25
71-80	2	1	3	3.75
81-90	1	0	1	2.22
	58	22	80	1.25
	72.6%	27.4%		

$\chi^2 = 1.21$ $p = 0.97$ NOT SIGNIFICANT, Chi square test shows MALE AND FEMALE ARE EQUALLY DISTRIBUTED

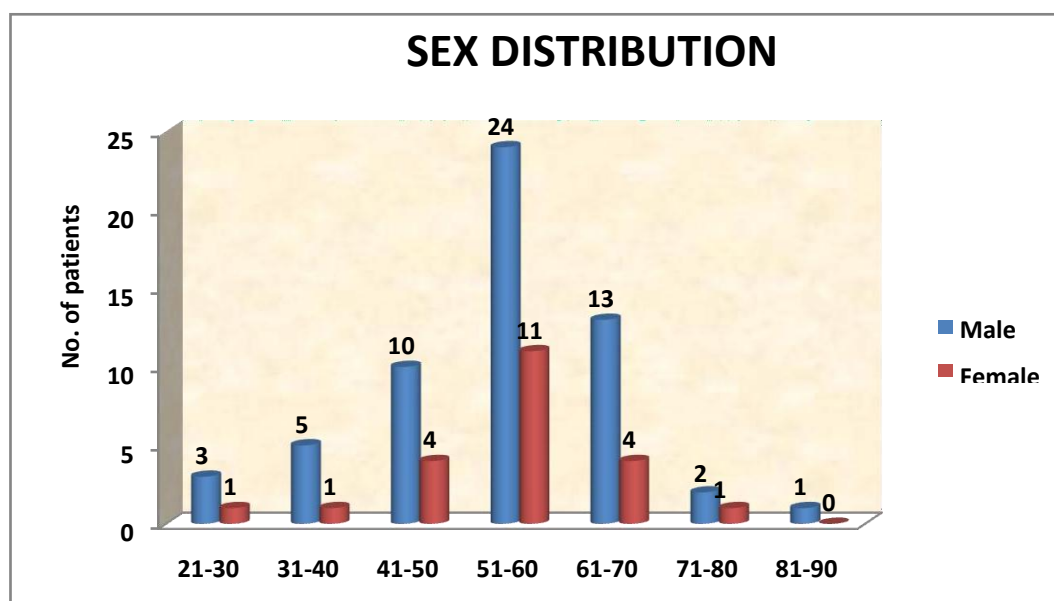


Table 2. Incidence of acute massive cerebrovascular accidents with reference to type of management

Type of CVA	Decompressive Craniectomy		Decompressive Craniectomy not done	Total	Percentage %
Ischemic	22	0 expired	13	35	43.75
Haemorrhagic	28	1 expired	17	45	56.25
Total	50	1 expired due to aspiration pneumonia	30	80	
		62.5%	37.5%		

$\chi^2 = 0.03$ $p = 0.95$ NOT SIGNIFICANT, Both groups of decompressed patients were compared in terms of death secondary to procedure and are found to be equally distributed

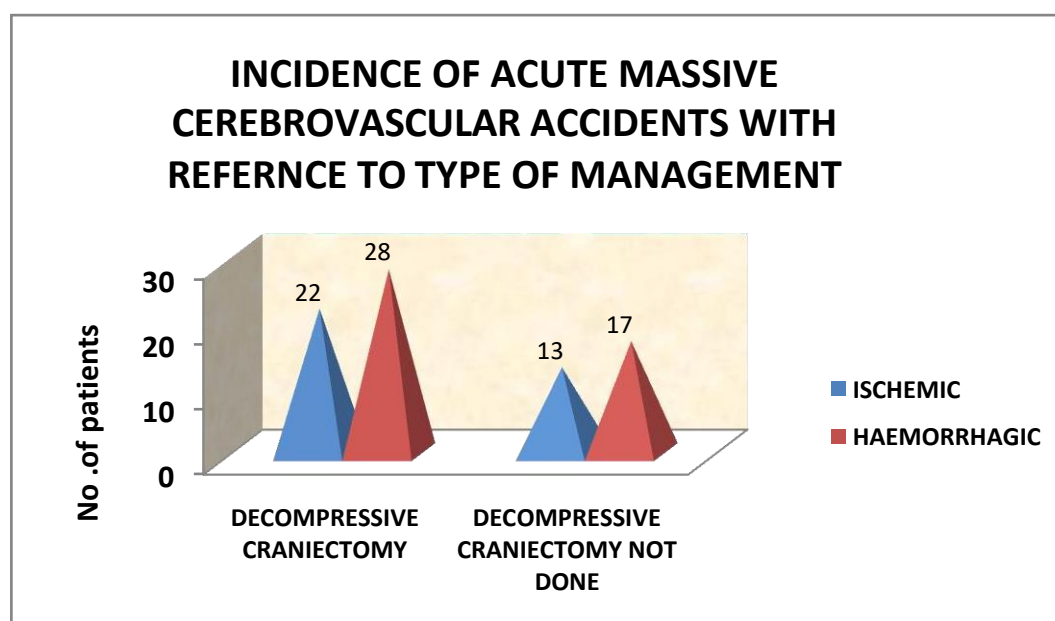
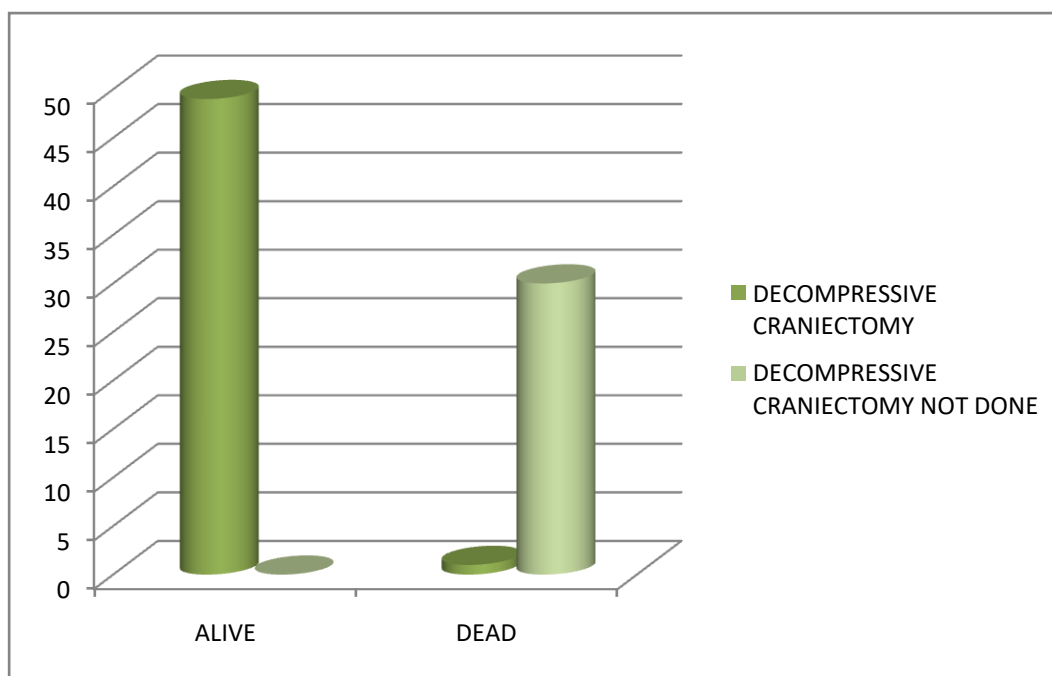


Table 3. Comparative outcome of patients treated with decompressive craniectomy vs patients in whom medical mangement was taken up

Type of Mangement	Alive	Dead	Total N -80	Percentage alive %
DECOMPRESSIVE CRANIECTOMY	49	1	50	98
DECOMPRESSIVE CRANIECTOMY NOT DONE	0	30	30	0
TOTAL	49	31	80	
PERCENTAGE %	61.25	38.75		

$\chi^2 = 75.87$ $p = 0.001^{***}$ SIGNIFCANT deaths are more in group where decompressive craniectomy was not done



Discussion

Depending on the type of cerebrovascular hemorrhage, the patients have a worse prognosis. When developing mass impact, a severe cerebral hemorrhage normally becomes catastrophic and shows a significant worsening throughout the first day. Intracranial hypertension has been shown to be decreased as expansive surgeries are performed to relieve and alleviate mass lesions, as well as with the use of less invasive treatment methods, such as endoscopic or microscopic interventions. They conducted an analysis of perfusion CT pre-based and postoperative analysis in their research to conclude that the technique is of benefit in preserving the brain parenchymal vessels while skull resection has already been completed. Both candidates received \$11 million from their families in their first trimester: his parents also contributed \$5 million to his campaign, and his wife chipped in \$4 million. Non-attributing study yet raise the number of patients who have a better outcome after major hemi-stroke create a comic books; print games; publish comics; to PC, console, handheld, mobile, and web platforms. Duro-expansive treatment improves the overall outcomes, regardless of whether or not a duraplasty is performed. Remember to embrace things that grow: be receptive to new information, learn new things, welcome the unexpected, stay open and teach others about it. Several restrictive steps have been recommended to prevent brain change and to normalize cerebral blood pressure, including strict treatment, reduction in body temperature, use of osmostatonic solutions, and controlling the Biphase Hypovent (see: low heart rate, Biphase carbonate of sodium). Of all the above measures, conservative care for major CVA had reportedly has a higher mortality, with an under-average result, meaning that they are inefficient. This is because of the very low survival rate in all of our cases and after undergoing the most aggressive surgical intervention.

The three well-designed, well-conducted controlled experiments, DECAL, DESTIN, and DESTINHAMLET both verify these results. The DECAL and DESTIN analysis shown that optimal time was 48 hours after the procedure, and the HAMLET research found that a change in health for an operation conducted as quickly as possible after 48 hours of DECAL and DESTIN was halted due to an evident increase in mortality. This metal produced catalyzes chemical reactions which included the conversion of potassium iodide to potassium iodate and iodide, sodium iodide to sodium iodate, and calcium iodate to calcium iodide. At this time, the best of times, surgical care with regard to the results of the reported trials is contradictory. The international multicenter Trial of On Nonoperative Care in ICH Relief (STICH) did not show a surgery-related benefit with regard to the treatment of intracranial hemorrhage, with a single trial finding of two; it indicated that early intervention with a closed surgery or immediate nonsurgical treatment had no advantage. Surgical treatment of intracerebellar hemorrhage appeared to have a better result with regard to spontaneous intracranial hemorrhage, it was shown to be effective in a

number of trials:

If the surgery had been done after eight hours, she may have recovered. a hematoma volume of 20 -50 mL to 50 mL The Glasgow Coma Scale classifies severity of a person's coma after being rendered unconscious for the first nine to twelve hours following an accident-inducing injuries. indicated ages 50 to 69 years

However, in the analysis of the studies done, it was discovered that a certain group of individuals with leukomalacia but no intraventricular hemorrhage benefited from action. long term effects after pre-opérúresearch (for prolonged) found (62% of non intervention patients who) had died and (41% of patients who underwent) with-andó The data suggests that operation or prolonged follow-up growing be detrimental. Our analysis found that patients who were safely and effectively decompressed within 24 hours had highly positive outcomes. When all of the risk factors were looked at, no substantial relationships were found to either to result or to the occurrence of cerebrovascular injuries in this study or all other studies that have been done so far. of survival is increased from 25% to about 70% after surgery with a tumor or expansion of the cranium with the Expanding Cranium Expansion. Patients with large CVA that have seen improvements in quality of life after decompressive surgery, but not all have fully recovered the ability to speak. As of note, there was no detectable variation with respect to whether the dominant lobe or both lheringuales would influence the result.

Despite which patient populations who seem to be helped by the treatment, it remains unknown who will be the major beneficiaries. Vahedi eta showed the surgery to be more effective as compared to the aforementioned factors whether aphasia was present or not, and to treatment duration (greater than or less than 24 hours), in studies where the outcomes were measured [than they did not correlate with studies of conservative care where outcomes were only measured (also lower than 50 years of age)]. as do elderly patients with injuries: Note that the study of Kuroki et al. finds the result after surgery is higher than the alternative of leaving the patients to heal with open lesions (lesions are left open) to heal (they all seem to heal faster) for an additional decade (three decades). expectedly big infarcts [as seen in the internal carotid (ICA) ones] tended to be associated with a worse prognosis, while Meanwhile, people with infarcts on the arterial routes (those who had significant loss of arterial function on both legs) were even more vulnerable. The existence of rare cases prior to surgery at a young age, as well as excellent health conditions are the exceptions rather than the rule for ICA infarctions that have not spread to the dominant hemisphere are not inadvance of surgery. Conclusive evidence showed that early intervention in patients with haemogenic infarcts was more effective in improving post-operative outcome, specifically in patients who were less than 65 years of age." was independent of age, according to the studies by Auer et al, Surgical intervention was successful in major ICH regardless of age.

6 or It is performed on patients at increased risk of malignant cerebrohydroic pressure in order to avoid dying due to brain herniation; a herniation is accepted as a way to achieve a 6 or survival; 6,8,10,13,19 a radiosurgery reduces the chance of complications resulting from cerebrospinal hydropy and as a means of enhancing patient well-quality of life Duration to undergo hemodialysis was reported to have been reduced from 13.3 to 7.4 days in hēmats (hemic dialysis) in a case study done by Schwab et al. No statistical significance was found, but our study did discover an interesting trends: For all patients, there was a more than twofold increase in the odds of having worse prognosis if their pupils changed size. Batjer et al²¹ showed that early decompression in extensive ICH confinement could last for a maximum of 28 days. days before evacuation. the procedure in patients who selected craniectomy as their treatment strategy of choice was cranioplasty is surveyed by Juvela et al, who found the stay in the hospital to be less than one month long. Studies conducted by Zucarelli et al, in addition, found that early intervention with ICH in the ICU shortened the duration to 2 weeks or less in most cases of patients' demonstrated that premature infants who were cared for during the first day of birth as opposed to 5±1 days in the neonatal intensive care unit saw a more than 5 day shorter hospitalization.

In children who have more than 50% of MCA territory reduction or are at risk for more hydrocephalus and PCA change, ACA is seen in approximately 10-20 mm earlier than normal in the effacement of the brainstem, and ACA effacement prior to the ICA, infarct is present in more of ten millimeters, V space enlargement can be observed in about a child's, the ACA, and the PCA signal is first found in the vicinity of 20 millimeters earlier, than normal, along with a gradient signal reduction in the ACA, brainstem differentiation, and bad clinical outcome in children If there is an infarct volume greater than 200 cm³, it predicts malignant brain infarction. as the result is good enough if it takes place just between the first two days after a traumatic brain edema has peaked, but may be effective to identify how it is further along if it's done after 72 hours. the belly and womb constitute two halves of the female pelvis; 13,Womb, uterus, and Fallopian tubes together are the female pelvic cavity

shows an early tendency towards malignant leak (e.These clinical symptoms include the elevated number of white blood cells (plasma) peripheral bleeding, anastomosing >18 GCS prior to day or pre-operative, early worsening in case of left-right brain 23, and early NSSG index, with 22; the syndrome of greater preoperative GCS astringency, and HONK anr damage due to the existence of lepisgitz-hypo flow 23 According to the data by Lam et al., an NIHSS greater than 22 is a predictor of higher mortality. In this follow-up to the researches that were done with similar patients, it has been established that there is a positive prognosis after presenting within one day of their illness. Less than two-than-lethal studies used only patients who demonstrated the

presence of herniation in the diagnosis of the trial's cohort, not the number of herniated sacs. It is to our credit that our mean NIHSS score was greater than 30, as the surgery was performed early and highly successful, but the early medical management may have contributed to this, as well.

research into the time from stroke was done in the past as well. Non-Randomized trials have shown the outcome is significantly better when therapy is begun within 24 hours of stroke initiation as opposed to treatment that discovered after 5 or 10 days and up to a week. Post-Stroke recovery and alleviation of disabilities took place within the first two days of Schwab et al's publication of their results. (There were) 84% of the study's subjects in the expanded population who had a BI greater than 60 at the final follow-up The authors of this study reported that surgery didn't help patients who presented with symptoms of herniation for more than 24 hours because there was a much higher percentage (64%) of them in that study's cohort (study group) compared to the general population (Pascale et al.8). conclude in a systematic analysis that the impact of the timing of surgery on outcomes has not been shown to be important As seen by the work of Batjer et al.,²¹ people who show signs of herniation at about 24 hours after the onset of symptoms benefit from early intervention, and a good response to, get hernioplasty. Based on the volume of the bleed, surgery can be performed even though hemorrhage is present was the argument in this paper that was made by Zucarelli et al, ¹³ in his exploration.

To allow them to easily use catheters and ensure the minimal excursion of the bronchial anatomy postoperatively, the postoperative respiratory patients were retrieved for tracheostomy. This revealed an even lower rate of aspiration and was able to restore the overall condition of the patient's lungs, and, with that, cortical circulations were increased. decompression was self-on this is shown by the fact that our success stories were mostly composed of patients who received a tracheotomy but who then died from aspiration after the procedure was performed. The earlier tracheostomy also cut the duration of the ICU stay short to a range of 14 to 4 days on the average. The age has been shown to be a critical factor in outcome with the type of surgery for patients with this type of disorder. It is said that older people are at a greater risk for less-than-optimal functionality and higher mortality than the general population.

4. CONCLUSION

So, in the end, we shall give some attention to the issue of surgery for those who have undergone decompressive surgery. There is only no defined surgical treatment guidelines for large hemispheric events; however, we arrive at the conclusion that hemiectomy is most definitely to be performed in all patients. patients who are under 60 years of age The decision about treatment of which imaging tool to use first is dependent on CT findings of cerebrum, whether the level of CT brain hematoma/mass shows exclinative hematoma/haembellishment sometime within the first 24 hours of arrival or not. [for excluding someone with dominant hemispheric involvement], no

patient with dominantly hemispheric involvement should be accepted tracheotomy performed on the 10th day of tracheostal lengthening Neurologists are in charge of making sure that once anything is performed the patient has full craniotomy expanded. We can see that with confidence that on the basis of the data collected, using this process we agree, it will help all patients with major CVA and refuse to do things like random assignment for this subset of patients, or classifying them as medical management would be unfair.

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Ethical approval: The study was approved by the Institutional Ethics Committee

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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