

Neurosurgery Nontraumatic Consult Guidelines

- No Neurosurgery Consult necessary:
 - Unruptured aneurysms - can see Dr Fautheree or Bowie as outpatient
 - Thunderclap headaches with “unruptured aneurysm” on CTA may have had sentinel bleed and require LP to assess for blood/xanthochromia. CTA is not as sensitive as angiography.
 - Seizure patients with known stable brain lesions
 - A neurology consult should be considered
 - Multiple Metastatic lesions < 1 cm with known primary disease without hydrocephalus or midline shift
 - If resection or biopsy is needed, Oncology can consult Neurosurgery as needed
- Neurosurgery Consult necessary:
 - Supratentorial IPHs
 - > 2 cm, or IVH
 - Hydrocephalus
 - Infratentorial IPHs
 - > 1.5 cm or IVH
 - Hydrocephalus/edema/obstruction
 - Acute/Chronic Subdural Hematomas > 5mm, or midline shift, or hydrocephalus
 - Supratentorial Ischemic CVA with hemorrhagic conversion > 2 cm, significant mass effect, or when failure of medical management is suspected and surgical decompression is deemed necessary
 - Infratentorial CVA with hemorrhagic conversion > 1.5 cm, or IVH, or when ventricular obstruction/hydrocephalus is evident or expected
- All lesions that do not meet these criteria should be directed to the CCMS Service.
 - This protocol is only a guideline for care. Any ongoing concerns should necessitate a neurosurgical consult.
- General considerations:
 - CTA should be ordered for all nontraumatic subarachnoid hemorrhages
 - All head bleeds, regardless of cause, should:
 - Be admitted for ICU observation
 - Receive Neuro checks q1h
 - Undergo a minimum of 1 follow-up CT head imaging within 24 hrs of admission to ensure stability of the lesion