AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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Dr Andrew Connolly
Acting Chief Medical Officer
Counties Manukau

22 September 2022

Dear Andrew,

Re: [redacted]

I have now the opportunity to look at [redacted] notes.

From the initial neurosurgical telephone advise, it is stated that [redacted] was at ED at 0100hrs on the 15 June 2022 she presented with a sudden onset of severe headache. At 0400 later that morning she had a respiratory arrest at home and [redacted] seen in ED.

The Ambulance team and Resus team were called to her home where she was resuscitated and then admitted to Middlemore Hospital.

Looking at her previous Medical History she was a known hypertensive, and from the Éclair Notes on Concerto the last prescription for Losartan 50 mg daily, was given to her 4th December 2020.

Whilst in the Emergency Department she had her CT scan of the head which showed diffuse subarachnoid haemorrhage no evidence of Hydrocephalus, blood in the basal cisterns as well as Intraventricular haemorrhage.

Due to the raised intracranial pressure there was no cerebral blood flow and therefore the CT angiogram could not image the intracranial arteries.

The working diagnosis is that [redacted] had a spontaneous subarachnoid haemorrhage of which the most common cause is ruptured intra-cranial aneurysm however in the absence of any CT angiogram one cannot be 100% sure of the cause of the SAH.

Looking at the potential risks of re-rupture within 24hr of the first subarachnoid haemorrhage, this is reported to be between 4 – 17%, which most cases occurring within 6 hours of the initial haemorrhage.

This appears to be associated with patients who have a much greater blood load in the subarachnoid space and patients who undergo external ventricular drainage to treat the post-subarachnoid haemorrhage hydrocephalus.

Would there be any difference to the outcome if [redacted] was admitted earlier?

Having reviewed all the clinical and radiological investigations potentially if she was hypertensive her blood pressure could be lowered slowly in hospital and this may and that's a big may have resulted in preventing further haemorrhage.

Aneurysms which cause Subarachnoid Haemorrhage are admitted to hospital and initially stabilised medically. Definitive treatment of an intracranial aneurysm is either endovascularly or surgically on the next available list. If the patient was admitted to our ward at 02:00 in the morning treatment would have been planned for the following day. Potentially whist in the ward she could still have had a fatal re-bleed.

The mortality rate from the re-bleed is reported to be 60 per cent.

Putting all the information together I do not believe that the delayed admission had any significant impact on [redacted] Pathology and final outcome.

If there is any further information you required please could you contact me.

With Regards

Yours sincerely

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