

Sygehistorie 1

- 22-årig kvinde kommer til vagtlæge. Debut 3 timer tidligere af flimrer for øjnene som varede ca. 20 min. Kort herefter bemærkedes 15 min. varende paræstesier i venstre arm. Efter kort tid ca. 20 min. varende paræstesier s.v.t. venstre mundvig. Ingen hovedpine. Meget opskræmt da moder havde noget lignende for 10 år siden, fik her konstateret "hjerneblødning". Moder har migræne. Yderligere anamnese? Tiltag?
- Henvises til skadestue u.d. apoplexia cerebri. Objektiv undersøgelse i.a. Synsforstyrrelser var typisk flimmerskotom. March af symptomer. Diagnose?
- Migræne aura uden hovedpine. Tiltag?
- Øget risiko for apoplexi? Rygning, hormonal kontraception?

P-piller og migræne

- Risiko for cerebralt infarkt hos yngre kvinder med migræne er i forhold til normalbefolkningen øget med
 - Migræne uden aura 1,6?
 - Migræne med aura 6
 - Migræne med aura + rygning 10
 - Migræne med aura + OC 14
 - Migræne med aura + rygning + OC 34
- Absolut risiko hos yngre kvinder med migræne
 - 18 tilfælde per 100.000 kvinde år

P-piller og migræne

- Migræne med aura er en risikofaktor for cerebralt infarkt
- Anbefaling
 - Patienter med migræne med aura bør ikke tage østrogenholdige p-piller eller ryge
- Kvinder over 45 år med migræne
 - Med aura har let øget risiko for cerebralt infarkt
 - Uden aura har ingen øget risiko for cerebralt infarkt

Case 2

- 17-year old girl with mild episodic posttraumatic headaches for 6 months presents in ER with subacute, severe holocranial headache for 2 days



Case 2

- Double vision otherwise no visual symptoms
- No family history of headaches
- No exposition to hormonal therapy, no medications, no endocrine diseases
- Diagnosis, what to do?

Case 2

- MRI and MRV (venous sinus thrombosis?) normal
- Lumbar puncture, 2 leukocytes, protein 0.39, glucose 3.0, pressure 44 cm water
- Neuroophthalmic examination: papilloedema, decreased vision, visual field defects, abducens palsy
- Blood tests normal (normal haemoglobin, coagulation status, SR and TSH)

Idiopathic intracranial hypertension

- Obese woman of childbearing age
- Headache
- Papilloedema
- Pulsatile tinnitus
- Transitory visual obscurations
- Diplopia (VI palsy)
- Visual field defects
- Increased CSF pressure (>200 mm H₂O in the non-obese, >250 mm H₂O in the obese)

Case 3

- 50-years old man, wakes up 23.5.2009 with pain in left side of neck and slight problem with pronunciation and slightly changed sensation in left side of face and right arm and leg
- Patient is over-weight and smoker
- CT-c normal
- Transferred to Glostrup 26.5 for further examination
- What to do?

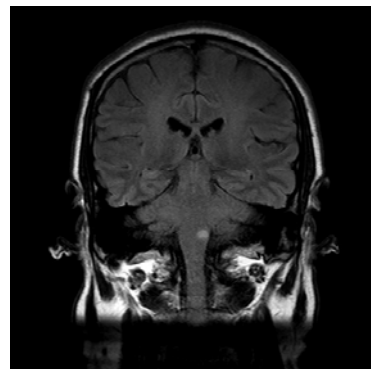
Case 3

- Further history
 - No headache, paresis, vertigo
- Examination
 - Slight dysarthria, slight dysesthesia in left V1, V2 and V3, decreased sensation to touch, pain and thermal stimuli in right arm and leg
 - Normal vibration sense, no paresis, hoarseness, Horner, ataxia or nystagmus
- Diagnosis? What to do?

Case 3

- Localization?
- Highly suspect for infarct in left lateral part of medulla oblongata (partial Wallenberg syndrome)
- Cause?
- Most likely caused by dissection in left vertebral artery (presented with pain in left side of neck)
- Order MR-angio

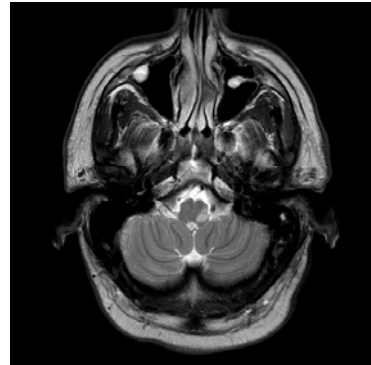
MR 27.5 - flair



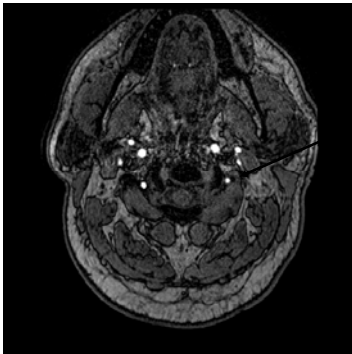
MR 27.5 – T2



MR 27.5 – T2



MR 27.5



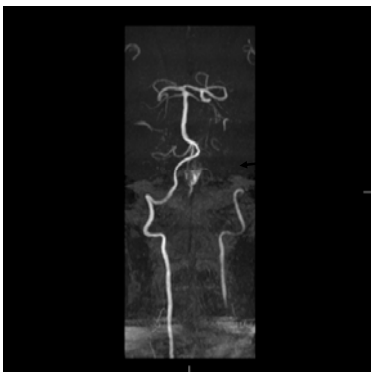
Flow in left vertebral artery

MR 27.5



No flow in left vertebral artery

MR 27.5

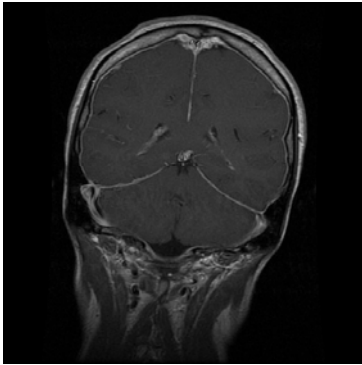


No flow in left vertebral artery

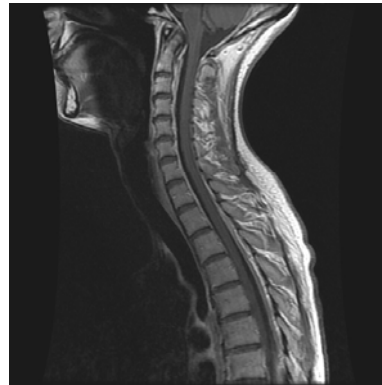
Case 4

- 37-year old woman, previously infrequent migraine without aura, otherwise healthy
- On April 12th 2008 she experienced a buzzing sound in right ear. Five days later she developed subacute severe constant headache behind both eyes and in the parietal region. First days disappearance when lying down, worsening when she got up. Accompanying photophobia, nausea, stiffness in neck and dizziness
- Admitted to hospital April 19th
- Objectively: Decreased hearing on right side, tenderness in neck muscles, temperature 38.1
- What to do, differential diagnoses?

30.4.2008 – Cor, T1 with contrast



30.4.2008 – Sag, cerv, T1 with contrast



Spontaneous low pressure headache

- Can be seen after increase in intracranial pressure (e.g. coughing) but also occurs spontaneously
- Headache worsens within 15 min after sitting or standing
- Accompanied by neck stiffness, tinnitus, hypoacusis, photophobia and nausea
- Other symptoms: vertigo, diplopia and cranial nerve palsies, most often abducens
- MRI: pachymeningeal enhancement
- CSF leakage on conventional myelography, CT myelography or cisternography
- The clinical picture will often be less typical over time