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Moždani udar – da li ga nekada previdimo?

Stroke - Do We Sometimes Overlook It?

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Apstrakt

Uvod: Akutni moždani udar (AIMU) se definiše kao naglo nastali fokalni ili globalni poremećaj moždane funkcije. To je bolest koju karakteriše nagli početak i brzi razvoj neuroloških simptoma.

Cilj rada: Ukazati da kod bolesnika sa akutno nastalim poremećajem ponašanja i bez vidljivih neuroloških ispada, treba da razmišljamo o mogućem šlogu.

Materijal i metodologija: Korišćeni su podaci iz lekarskog izveštaja i otpusne liste za prikaz slučaja pacijenta sa ishemičnim moždanim udarom.

Rezultati: Prikazan je slučaj muškarca starosti 66 godina, kod koga je iznenada nastupio poremećaj ponašanja i stanje psihomotornog nemira, praćeno konfuzijom i povremenom agresijom. Po dolasku, zatičemo pacijenta u kupatilu kako pali i gasi veš mašinu, a od supruge dobijamo podatak da se pre 3 sata probudio i počeo čudno da se ponaša (mokrio po kući). Pušač je, ne konzumira alkohol, zna za povišene vrednosti pritiska, ali ne uzima nikakvu terapiju. Uspostavljamo verbalnu komunikaciju, ali pacijent je konfuzan i uznemiren, pa iako tečno govori, povremeno ubacuje pogrešne reči koje nemaju nikakav smisao. Pokretan je, izvršava pojedine proste naredbe, ali nema uvid u sopstveno stanje, odbija našu pomoć, opire se pregledu, kao i odlasku u bolnicu. U najvišem interesu bolesnika pozvana je patrola policije da bi se sprovelo dovođenje pacijenta u zdravstvenu ustanovu.

Po dolasku policije, merimo TA 240/120 mm Hg i glikemiju 7 mmol/l. Za detaljniji pregled, pacijent je nesaradljiv. Kako su tegobe nastupile iznenada, a odbacili smo sumnju na mogućnost intoksikacije, pacijent je transportovan neurologu pod sumnjom na moždani udar, koji je dokazan nakon neuroradiološke dijagnostike.

Diskusija: Dijagnoza AIMU postavlja se u što skorijem vremenskom roku od prvih tegoba (od 3 do maksimum 4 ili 5 sati), kako bi se što pre započela trombolitička terapija. Veliku grešku bismo učinili da smo automatski pretpostavili da se radi o psihičkom poremećaju, te tako izgubili dragoceno vreme.

Zaključak: Kod svakog pacijenta kod koga nastupi akutni poremećaj mentalnog funkcionisanja potrebno je razmišljati o mogućnosti organskog poremećaja koji leži u osnovi istog, te isključiti potencijalno vitalno ugrožavajuća stanja kao što su: hipoglikemija, moždani udar, subduralni hematom, meningoencefalitis itd.

Abstract

Introduction: Acute stroke is defined as a sudden focal or global disorder of brain function. It is a disease characterized by sudden beginning and rapid development of neurological symptoms.

The aim of the paper: To indicate that in patients with an acute behavioral disorder and without visible neurological symptoms, we should consider a possible stroke.

Material and methodology: Data from the medical report and discharge list were used to describe the case of a patient with an ischemic stroke.

Results: The case of a 66-year-old man, who suddenly developed a behavioral disorder and a state of psychomotor restlessness, followed by confusion and occasional aggression, is presented. Upon arrival, we find the patient in the bathroom turning the washing machine on and off, and we get information from his wife that he woke up 3 hours ago and started behaving strangely (urinating around the house). He is a smoker, does not consume alcohol, and knows about elevated blood pressure values, but does not take any therapy. We establish verbal communication, but the patient is confused and agitated, so even though he speaks fluently, he occasionally throws in wrong words that do not make sense. He is moving with ease and carries out some simple commands, but has no insight into his condition, refuses our help, resists examination, and going to the hospital. In the patient's best interest, a police patrol was called to bring the patient to the health facility.

After the arrival of the police, we measure blood pressure 240/120 mm Hg and glycemia 7 mmol/l. For a more detailed examination, the patient is uncooperative. As the symptoms appeared suddenly, and we rejected the possibility of intoxication, the patient was transported to a neurologist under the suspicion of a stroke, which was proven after a neuroradiological diagnosis.

Discussion: The diagnosis of AIS is made as soon as possible after the first symptoms (from 3 to a maximum of 4 or 5 hours) so that thrombolytic therapy can be started as soon as possible. We would have made a big mistake if we had automatically assumed that it was a psychological disorder, thus wasting precious time.

Conclusion: In every patient who has an acute disorder of mental functioning, it is necessary to think about the possibility of an underlying organic disorder, and to rule out potentially life-threatening conditions such as hypoglycemia, stroke, subdural hematoma, meningoencephalitis, etc.

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