CASE PRESENTATION
Headaches and Stroke.

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HISTORY

- Mr M.S, 45 y/M, known hypertensive for past 3 years on amlodipine 10mg, telmisartan-H 80/12.5, artovastatin 20mg but reported poor drug adherence, not diabetic, presented with a four day history of severe headache, of sudden onset, constant and throbbing in nature, involving the frontal and parietal region associated with blurred vision, not relieved by any pain medication and aggravated by bright light. He reported no muscle weakness, no slurring of speech. He also reported no episodes of reduced level of consciousness or loss of consciousness or fits.
- He reports no history of trauma, no history of alcohol use, no history of smoking.
- He however reports this was his second admission, the first being at Mengo hospital presented with similar symptoms and he was managed for intra-ventricular hemorrhage.
- Reports a paternal familial history of hypertension.

Primary survey

Airway	**PATENT** **PT Able to talk**	
Breathing	RR-18cpm,SP02-97% RA Chest is symmetrical, Bilateral equal air entry, no added sounds normal percussion	
Circulation	Normal JVP no pallor no edema. Normal pulse rate70 bpm full volume pulse, BP=203/137mmHg, CRT <2s	IV Labetalol 20mg; every 20minutes until BP<160/90. Blood samples taken:-CBC, RFT, lipid profile, RBS, Serum electrolytes

Disability / Drugs	**Anxious and restless in pain oriented in T.P.P. No focal neurology deficits noted. GCS-15/15, UL+LL tone, power and reflexes all intact. RBS-6.1mMol/L**	**When recommended BPs achieved initiate; PO Amlodac 10mg, PO Telmisartan-H 80/12.5mg PO Atorvastatin 20mg PO TRAP 50/325mg,**
Exposure	Abdomen-normal fullness, soft , no palpable organomegaly	
Non-contrast brain CT	Noted Noncontrast computed tomography scan of the brain that demonstrates a hyperdense region (an acute hemorrhage) in the right cerebral hemisphere, with surrounding white matter hypodensity consistent with vasogenic edema.	**Continue meds.**

Follow- up after 30 mins

Airway	Patent	
Breathing	RR- 20cpm Equal chest expansion normal air entry bilaterally SPO2-98% on RA	
Circulation	BP-156/103mmHg,PR-83, CRT<2s	Stop labetalol, start oral meds.
Disability /Drug	Headache reduced, complaining of dizziness	
Exposure	Abdomen-normal fullness, no obvious abnormalities.	

S	Signs and symptoms	severe headache associated with dizziness and blurring of vision.
A	Allergies	None
M	Medications	Antihypertensives and artovastatin with poor drug adherence
P	Past medical history	Known Hypertensive, second admission with similar complaints.
L	Last meal	Supper the previous night.
E	Events	Was at work on the first day these symptoms presented, progressively increased in intensity until day of presentation. NO h/o trauma

ON EXAMINATION

- GENERAL EXAM; middle aged, anxious and restless in pain, not in obvious distress. (JACCOLD)
- CVS ; peripheries warm, cap refill<3s,pulse present, regular, HS1+2 +0.
- P/A; normal fullness, moving with respiration, soft , non-tender, no organomegalies appreciated.
- R/S; rr-18, trachea central, bilateral equal chest expansion and air entry, normal percussion note, chest clear.
- CNS EXAM; oriented in T.P.P, PEARL, neck soft, No focal neurology deficits noted. GCS-15/15, UL+LL tone, power and reflexes all intact.

Problem list

- Uncontrolled BPs
- Severe headache
- Dizziness

Follow up

- Non-contrast brain CT- Noted Noncontrast computed tomography scan of the brain that demonstrates an acute hemorrhage in the right cerebral hemisphere, with surrounding white matter hypodensity consistent with vasogenic edema.
- Reviewed by physician; recommended tighter blood pressure control (added PO nevibolol 5gm) but with target MAP >65% and empasised drug adherence.
- Follow up BPs- 142/92, 133/86,128/84.
- Patient reported gradual reduction in headache, with very mild headache with no dizziness or blurring of vision reported on discahrge.
- Repeat CT recommended on next review in neuro clinic.

THE END

- **Thank you**.