

Case Report

Basilar Artery Aneurysm

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- Basilar artery
- Treatment
- Therapy dilemmas

Abstract

In the article we showed the patient, a woman with unruptured giant aneurysm of basilar artery, we showed the done examinations, and therapy dilemmas about what to do in the given case. We found in literature a number of examples which suggest operation treatment, but of embolisation too, some suggest conservative treatment.

INTRODUCTION

Intracranial aneurysms are vascular abnormalities which ruptures presents subarachnoid bleeding. It happens in the age from 35–65 years, and mostly between 55 and 60 years, 60% of ruptured aneurysm are found in women. Giant aneurysms are defined as those with diameter is 25 mm or bigger, 60% are in anterior, 40% are in posterior circulation with predilection in vertebrobasilar arteries. Aneurysms originate as effect of prolonged hemodynamic stress, with important role of relationships of anatomic locality, hemodynamics and degenerative factors. Physical exertions and emotional stress are precursors of rupture [1]. Unhemorrhagic symptoms and the signs of unruptured aneurysms are manifested as »mass effect«, thrombosis, embolisation, epileptic attacks, irritation of meninges. Diagnosis is stated through neuroradiological treatment: computed tomography (CT), multi slice-computed tomography of brain (MSCT), multi-slice angiography (MSCT angiography), magnetic angiography (MRA), cerebral angiography-digital subtraction angiography (DSA). Cerebral angiography is »gold standard« for diagnostic and aneurysm evaluation [1]. Most of aneurysms of brain arteries with the locality in anterior circulation is treated by titan »clips«, in posterior circulation with »coil« from platinum (Guglielmi), which is since 1995 acknowledged by FDA as sure and effective method of treatment, made better by biological active material on the surface polyglycol/poly lactate acid which covers platinum and decreases the risk from aneurysm recanalisation [2–6].

CASE REPORT

The 63-years-old woman was accepted to the Department of Neurology because of fast loss of sight on both eyes, dull headache in occipital region, afterwards nausea and vomiting. She did not lose consciousness and denied head trauma. Anamnestic: she is hypertensive for many years, at acceptance a very high value of blood pressure. Neurologic state at acceptance: very slowly, asymmetry of the lower part of the face-skin deep left nasolabial furrow, during examination weakened sight on both eyes, sees only shadows, somatic hypertensive.

The following examinations performed: CT of the brain: Native and with application of contrast medium: on both sides occipital-encephalomalacia, and new ischaemic lesion right, suprasellar right round hyperdense lesion which was after application of the contrast medium specifically opacified and which initiated aneurysm. Pancerebral angiography: Giant aneurysm of basilar artery- on the right contour medium third part of basilar artery of wide neck. Dilated type of other MSCT angiography: in the area of medium part of basilar artery we see saccular aneurysm with the beginning on the right lateral wall with direction cranial in the length 25 mm, dolichoectasy of basilar artery as well as carotid arteries-ACI.

We consulted: neurosurgeon who did not recommend operation for the reason of the size and statement of aneurysm, and risk conditions, and neuroradiologist who tries to perform endovascular intervention. Tried embolisation was not successful, and for that reason conservative treatment was continued. During hospital treatment with antihypertensive and antiaggregation therapy, blood pressure was normal value, laboratory parameters were normal. After 4–5 weeks patient had a great headache of pulsatile character, with prompt disturbance of consciousness to deep coma. There was a doubt of rupture of existed aneurysm. CT of the brain showed great unruptured aneurysm of basilar artery and great recent ischaemic lesion of cerebellum and brain trunk and brain parenchyma parietooccipital left, in the area of thalamus, with compression of III and IV ventricle which caused by edema. She died after 24 hours. Autopsy was not done (family overload).

DISCUSSION

The clinical dilemma what to do with the patient with unruptured giant aneurysm of basilar artery, with added risk factors for cerebrovascular illness: arterial hypertension, atherosclerosis, adiposity, to decide whether endovascular or operative or conservative treatment?

The examples from literature, as well as from clinical practice

showed that the decision is individual, concerning risk factors and the greatness of aneurysm.

The risk of death is too high for non operated aneurysms for the reason of embolisation of intraaneurysmatic situated thromb and followed ischaemia distal from aneurysm and possibility of rupture, and it is 14.5%–40% [7]. The data from literature show always the same dilemma: surgery (operation) or endovascular (coil placing) or conservative treatment [1,7-9,16-20]. The lowest risk for rupture has the aneurysm located in the anterior circulation if not greater from 10 mm in diameter. The greatest risk for rupture has aneurysm 10 mm in diameter or bigger located in posterior circulation. The risk can be made lower by very careful anticoagulation, antihypertensive therapy, avoiding of physical activities and by lowering of other risks, but epidemiological data are not very good and took about very high grade of individuality, further of death during next 5 years [1,8].

In the decision of therapeutic treatment very important role has the configuration of aneurysm. If it is longish and narrow, it is better for coil, and otherwise not [10,16-20]. ISAT study has proved that therapeutic decision of ruptured intracranial aneurysm is same good endovascular and neurosurgical treatment, but concerning risks from new bleeding is more frequent of endovascular treatment [11]. Recovering of the patient with the damage of posterior circulation, whether if it is infarct of aneurysm, need very careful physical therapy with limited possibilities of recovery of neurological attacks: walk-balance, sight, sensory functions [12-15].

Diagnosis will be given through non invasive and invasive diagnostic treatment, near interdisciplinary cooperation of neurologist and neurosurgeon with radiologist neuroradiologist, anesthesiologist, as well as doctor known risk factors and possible decisions, to get the highest quality of life of such patients. The patient from our description died for the reason of massive ischaemic cerebral infarct which developed as consequence of mobilisation of intraaneurysmatic situated thromb distal from aneurysm 24 hours after starting of headache, and after that comma statement and not for the reason of rupture of aneurysm. Unfortunately, autopsy was not done (family overload).

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