Multiple cerebral aneurysm – case report

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Abstract

This 41-years-old female presented with somnolence, confusion and nuchal rigidity. Preoperative angio-CT scan showed two aneurysm located on both internal carotid artery (ICA) at the site of posterior communicating artery (PComA). During surgery we discovered another dilatation on the origin of left ophtalmic artery that proves to be an infundibullum. We clipped the two communicating posterior aneurysm from the left side and the ophtalmic infundibullum was wrapped. Seven days after surgery the neurological status was improved and she was transferred to the Neurological department.

Key words: multiple cerebral aneurysm, subarachnoid hemorrhage, internal carotid artery, posterior communicating artery.

Introduction

Aneurysms are acquired lesions and the rupture of this lesions lead to subarachnoid hemorrhage (3). The incidence of multiple cerebral aneurysm is within 8% to 44% (5). The most common localization site of multiple aneurysm are on the middle cerebral artery (MCA), ICA and on the anterior communicating artery (ACoM) (4). In our series the most frequent combination was between ACoM-MCA and ACoM-PComA. In almost all cases the rupture occurred on ACoA aneurysm. A special group of multiple cerebral aneurysm are represented by the mirror-like aneurysm with an incidence between 5-36% (1).

Like in other studies, in our series too, the female represent the majority from the sex ratio point of view (2, 6, 7). The maximum incidence of aneurysmal rupture was reported in the fifth decade. The majority of multiple aneurysm were situated on the middle cerebral artery and the internal carotid artery (4).

Concerning the approach, we prefer to use unilateral approach for multiple cerebral aneurysm (“single stage – single opening”). This type of approach (“single stage – single opening”) we perform after 3-4 days from the rupture because at that moment we will have a good brain relaxation, clinical and metabolically stability.
Case report

A 41-years-old female patient who was admitted in our Service from the Neurology department with a 24 hours history of headache, somnolence and focal motor seizures in the right superior limb. At the neurological examination the patient presented a GCS of 13 points, nuchal rigidity, somnolence, confusion and she was without any motor deficits.

We performed a CT scan that show as subarachnoid hemorrhage in the basal cistern and in the left Sylvian fissure. The patient also presented intraventricular hemorrhage in the fourth and third ventricle (Figure 1).
After that we performed an angio-CT and that showed two aneurysms on the left and right ICA at the site of PComA (Figure 2).

The operation was performed in the second day after admission. After the endotracheal induction of general anesthesia, the patient was placed in a supine position, with the head slightly raised and turned to the right side. A left frontotemporal craniotomy was the chosen approach. Dural opening was parallel with the skull base. After the dissection of the left Sylvian fissure, the left optic nerve and the supraclinoidal segment of ICA we observed a dilatation on the ophtalmic part of ICA that proved to be an infundibullum (Figure 3). The left anterior clinoid process was resected intradurally in order to better define the neck of the aneurysm, than the definitive clip was placed on the left PcomA, along with wrapping of the left opthalmic infundibullum. After the dissection of the arachnoid over the optic nerves and chiasm, the lamina terminallis was opened in order to have a better brain relaxation. The dissection was continued on the opposite side, above and beyond the contralateral optic nerve and ICA. The dissection of the aneurismal neck was uneventful, and a curved definitive clip was placed on it, with a complete occlusion of the aneurysm. A standard wound closure with watertight duroplasty with autolog pericranium was performed. A follow-up CT – angio was performed at 48 hours postoperative period, demonstrating complete occlusion of the aneurisms with a normal caliber of both ICAs, with no additional brain lesions due to surgery (Figures 4, 5 and 6). The postoperative course was uneventful, with a progressive improvement of neurological status. After seven days of hospitalization the patient, at a GOS (Glasgow Outcome Score) of four was transferred to the Neurological department to continue the medical treatment.
From our point of view we consider is better to make only one opening because is the less invasive technique to manage multiple aneurysms and in our series we had good results.

In our series the mortality of patients with H&H third grade was 10%. Also, in our series, 64% of patients with H&H third grade were discharged with a Glasgow outcome scale of 4 or 5.

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References