The patient was moved to the emergency unit, and intubated. He was extubated the next day and by postoperative day 3 was progressing admirably: neurologically ready, verbal without aphasia, and following orders. After a month, another angiography found that contrasted and past pictures and CT checks, the vertebro-basilar supply route indicated discharge goal in the prepontine reservoir. What's more, his urinary maintenance improved after brief cystostomy and had totally recuperated constantly he left emergency clinic. His reciprocal abducens nerve paralysis slowly recuperated and a half year later he had typical visual developments. In the interim, follow-up angiography discovered total impediment of the vertebral aneurysm.

As far as anyone is concerned, there has been no past announced instance of aneurysm with two-sided abducens nerve paralysis and urinary retention. The abducens nerve is exceptionally sensitive to any sort of brain disability, most likely in light of its incredibly long extracerebral intracranial course. Injuries causing abducens nerve paralysis might be situated in the cerebrum stem, subarachnoid space, petroclival area, huge sinus, or in the circle along the course of the nerve. Accordingly, differential finding of abducens paresis is expansive, with a few basic illnesses known, despite the fact that its etiology stays muddled in more than 66% of cases. Disconnected or joined abducens nerve paralysis might be seen with aneurysms of various veins, including the infracorollar inner carotid, intracavernous carotid, front conveying, basilar, predominant cerebellar, vertebral, and back sub-par cerebellar supply routes. Abducens nerve paralysis brought about by VA aneurysm has seldom been accounted for. Patients generally present with look paralysis that is two-sided or ipsilateral to the neurotic injury. Potential instruments of separated nerve paralysis identified with VA aneurysm can be partitioned into a few gatherings: direct pressure by the aneurysm, cerebrum stem, or nerve pressure due to cisternal hematoma (particularly the prepontine storage), stretch nerve injury on the petrous peak set off by expanded ICP, and vascular deficiency due to vasospasm of abducens cores.

We report a patient who displayed bilateral abducens nerve paralysis and urinary retention brought about by a ruptured vertebral aneurysm. We speculate that the bilateral 6th nerve paralysis and urinary retention were because of direct pressure of the blood coagulation on the connected nerves. This case accentuates the significance of keeping a wide, receptive outlook in moving towards the maintenance and the board of urinary retention related with cranial nerve symptoms and responding rapidly to clinical turns of events.