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INTERNAL CAROTID ARTERY ANEURYSM OPEN REPAIR WITHOUT MANDIBULAR SUBLUXATION: A CASE REPORT

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Extracranial carotid artery aneurysms (ECCAs) are rare, with an estimated incidence of less than 1%. They can have different etiologies: atherosclerotic (main etiology), dysplastic, infectious, inflammatory and post-traumatic. The diagnosis can be made by CT-angiogram, but the gold-standard is digital subtraction angiography. Their treatment, not yet been well established, can be open repair, which is a safe surgical option with low prevalence of complications (mostly cerebral ischemia) endovascular repair, or conservative. Most open repairs require submandibular subluxation, because of the site of the aneurysm. We describe the case of a 61-year-old white woman with a cervical bulging, pulsatile at the physical exam, and occipital headache. CT angiogram showed: signs of dissection of right vertebral artery and a fusiform aneurysm dilatation of the left internal carotid artery. Since patient had two different types of lesions in two different artery sites, the possibility of fibromuscular dysplasia was considered as a differential diagnosis. Since the kinking made endovascular repair unfavorable to be done, open repair was opted and an aneurysm resection was carried out, with primary end-to-end anastomosis of the internal carotid artery with the internal carotid artery. During the surgical procedure, it was noticed that, because of the location and kinking of the aneurysm, the mandibular subluxation wasn't necessary (an uncommon feature for this type of surgery). The products of the biopsy specimen were cultured and analyzed histo and anatomopathologically which subsequently excluded the possibility of FMD.

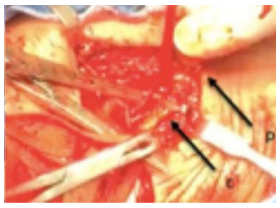

Figure 1: End-to-end anastomosis (c) of the ICA.

Figure 2: Patient's bulging on left cervical area 2 (arrow).

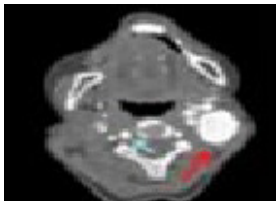

Figure 3: CT angiogram — left interior carotid aneurysm (red arrow); vertebral artery dissection (blue arrow)..

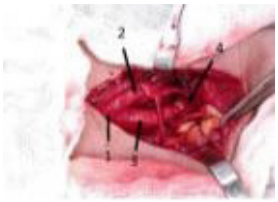

Figure 4: Internal carotid aneurysm shown after dissection (1 = common carotid artery (CCA); 2 = external carotid artery (ECA); 3 = internal carotid artery (ICA); 4 = post anastomotic ICA)

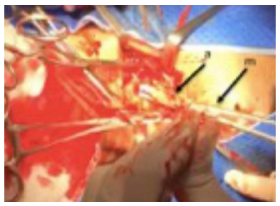

Figure 5: Partial resection of the aneurysm (a - aneurysm; m- metzenbaum)

Recent Publications

1. Jiber H, Zrihni Y, Naouli H and Bouarhroum A (2017) Fibrodysplasic aneurysms of the extracranial internal carotid artery: a new case report. Pan Afr Med J. 28:170.
2. Jin C, Hu Z and He Y (2017) A wide-necked extracranial internal carotid artery saccular aneurysm with ipsilateral proximal compression. J Clin Ultrasound 45(2):116-120.
3. Yamamoto S, Akioka N, Kashiwazaki D, Koh M, Kuwayama N and Kuroda S (2017) Surgical and endovascular treatments of extracranial carotid artery aneurysms-report of six cases. J Stroke Cerebrovasc Dis. 26(7):1481-1486.
4. Hongo H, Inoue T, Tamura A and Saito I (2017) Surgical strategy to minimize ischemia during trapping/resection of giant extracranial carotid artery aneurysm stratified by collateral evaluation. Surg Neurol Int. 8:28.
5. Guzhin V E, Dubovoy A V and Cherepanov A V (2016) Surgical treatment of distal extracranial internal carotid artery aneurysms associated with pathological artery kinking. Zh Vopr Neirokhir Im N N Burdenko. 80(5):62-66

Biography

Rezende A N C A is a vascular resident with an interest in Arterial Pathologies and Surgery. Her main goal is to bring an up to date treatment to her clients. She has built this model after years of experience in research, evaluation, and student orientation in Ipiranga Hospital, Brazil. Her Alma mater is an internationally known university (State University of Campinas - UNICAMP) which introduced her to research.

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