Rare PTA variant (Saltzman type IIIa) associated with multiple cerebral aneurysms

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DESCRIPTION

A 68-year-old woman with a history of hypertension, hyperlipidemia and 10 pack-year smoking history presented with sudden onset of the worst headache of her life. She denied any family history of brain aneurysms. CT angiography (CTA) revealed a subarachnoid haemorrhage due to a ruptured right posterior communicating artery (P Comm) aneurysm (6.8×6.7 mm) with a small temporal lobe haematoma adjacent to the right P Comm artery aneurysm dome (figure 1). She underwent a cerebral angiogram that demonstrated multiple aneurysms, including an anterior communicating artery (A Comm) aneurysm (7.8×3.8 mm), left posterior cerebral artery aneurysm (4×2.5 mm) and anterior choroidal artery aneurysm (1.4×0.5 mm). A persistent trigeminal artery (PTA) originating from the lacerum portion of the right internal carotid artery (ICA) was incidentally noted on catheter angiogram (figure 2). The PTA originated from the lateral aspect of the right ICA before coursing towards the posterior fossa where it supplied the superior portion of the right cerebellum. Diffuse, irregular appearance of the cerebrovascular system, consistent with advanced atherosclerotic disease, was also noted on angiography. The patient underwent coil embolization of the right P Comm aneurysm. After uncomplicated embolization of the P Comm aneurysm, she developed concordant ECG and haemodynamic changes. The embolization of the A Comm aneurysm was aborted for urgent cardiovascular evaluation. Her hospital course was further complicated by delayed cerebral ischaemia requiring aggressive medical and endovascular treatment. The patient was discharged to a rehab facility after a complicated hospital course. She was cleared by cardiology for the treatment of A Comm aneurysm. The patient was admitted electively 2 months later, and the A Comm aneurysm was successfully treated with stent-assisted coil embolization. The patient was discharged on dual antiplatelet therapy. The patient was seen 2 weeks later through telemedicine clinic visit and was doing well. She is scheduled for a repeat catheter angiogram 6 months after her A Comm aneurysm embolization.

Park et al reviewed 3552 cerebral angiograms, and five cases of PTA variants (incidence of 0.14%) were noted, among which only one case was a Saltzman type IIa variant (incidence of 0.02%). Uchino et al reported the incidence of PTA variant (Saltzman type III) to be approximately 0.18% on digital subtraction angiogram (DSA) and 0.76% on MR angiography. Siqueira et al reviewed 5500 angiographic studies over 4 years and found 11 cases of PTA variant (incidence of 0.18%). Shoja et al reported a case of a 52-year-old white woman who presented with headache and subarachnoid haemorrhage; CTA revealed no aneurysm, however it demonstrated a left PTA originating from the cavernous ICA. Bykowski et al also reported a case of PTA (type IIIb) associated with a cerebellar infarct in a patient who presented with dysmetria and gait imbalance. Hwang et al reported a 39-year-old woman who presented with headache due to a subarachnoid haemorrhage. CTA and DSA revealed PTA variants (Saltzman type IIIb and type IIIc) with multiple cerebral aneurysms. We are reporting a very rare case of PTA Saltzman type IIIa associated with multiple cerebral aneurysms.
It is important to be aware of this anatomical variant, given the risk of deviation of emboli in therapeutic endovascular procedures, potential risk of brain stem and cerebellar ischaemia, and risk of ischaemia and haemorrhage by surgical manipulation of these vessels with posterior fossa approaches. The blush seen in angiograms might also be misinterpreted as tumour or ischaemia.3

Whether the persistence of carotid-vertebrobasilar anastomosis predisposes patients to an increased risk of aneurysms remains a highly debatable point. Alteration of the haemodynamics predisposes patients to an increased risk of aneurysms ischaemia.3 Alteration of these vessels with posterior fossa approaches. The blush and risk of ischaemia and haemorrhage by surgical manipulation, potential risk of brain stem and cerebellar ischaemia, and risk of ischaemia and haemorrhage by surgical manipulation of these vessels with posterior fossa approaches. The blush seen in angiograms might also be misinterpreted as tumour or ischaemia.3

REFERENCES