ESTENOSIS SEVERA DE LA ARTERIA VERTEBRAL IZQUIERDA-OCLUSIÓN DE LA ARTERIA VERTEBRAL DERECHA

Enfermedad Actual

El paciente presentó el día 25/10/17 un episodio de pérdida de fuerza en m. sup derecho, alteración en la

articulación del lenguaje seguido de movimientos anormales en m. sup derecho y pérdida de consciencia.

Según refiere su esposa permaneció inconsciente 10 minutos y tras la recuperación lo notan desorientado.

El día 3 de Noviembre presenta otro episodio de alteración de la articulación del lenguaje e ingresa en

Neurología en Guadalajara.

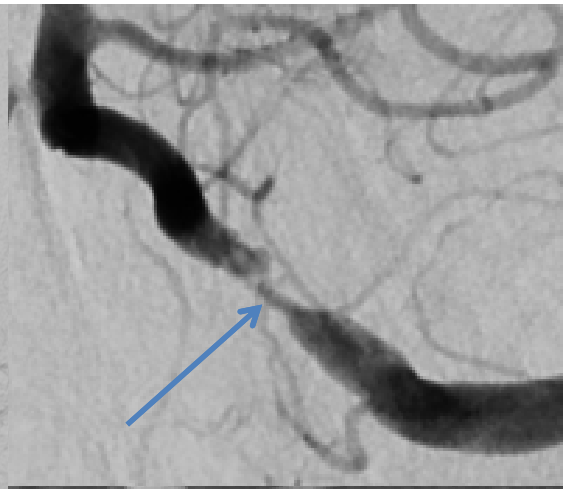
Traslado a Toledo:

RM craneal

Áreas de isquemia en 3 territorios

diferentes, PICA bilateral y ACP izquierda.

Arteriografía cerebral diagnóstica: "Severa estenosis de la a. vertebral izquierda en su segmento intracraneal, de una longitud de aprox. 25 mm., con adecuado relleno distal. Oclusión de la arteria vertebral derecha en segmento distal con Pica derecha permeable.



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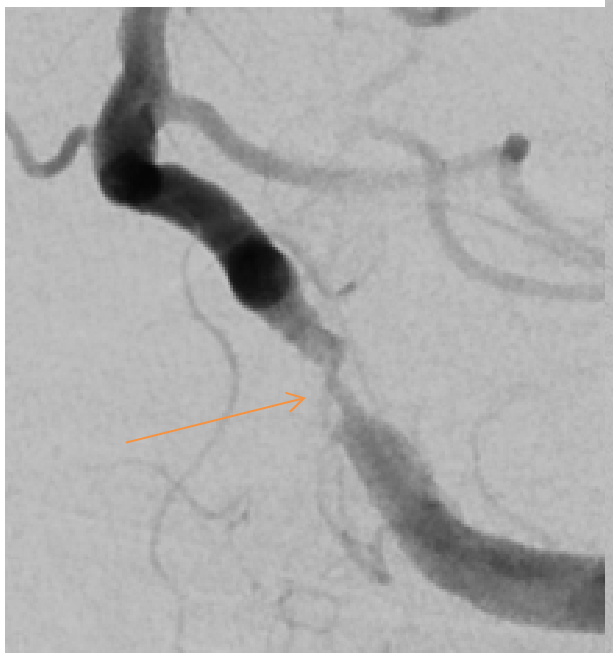
Arteriografía cerebral:

Arteria vertebral derecha ocluida en segmento distal a Pica.

Arteria vertebral izquierda con estenosis preoclusiva en segmento intradural.



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Clinical Neurology and Neurosurgery 143 (2016) 132–138

Contents lists available at ScienceDirect

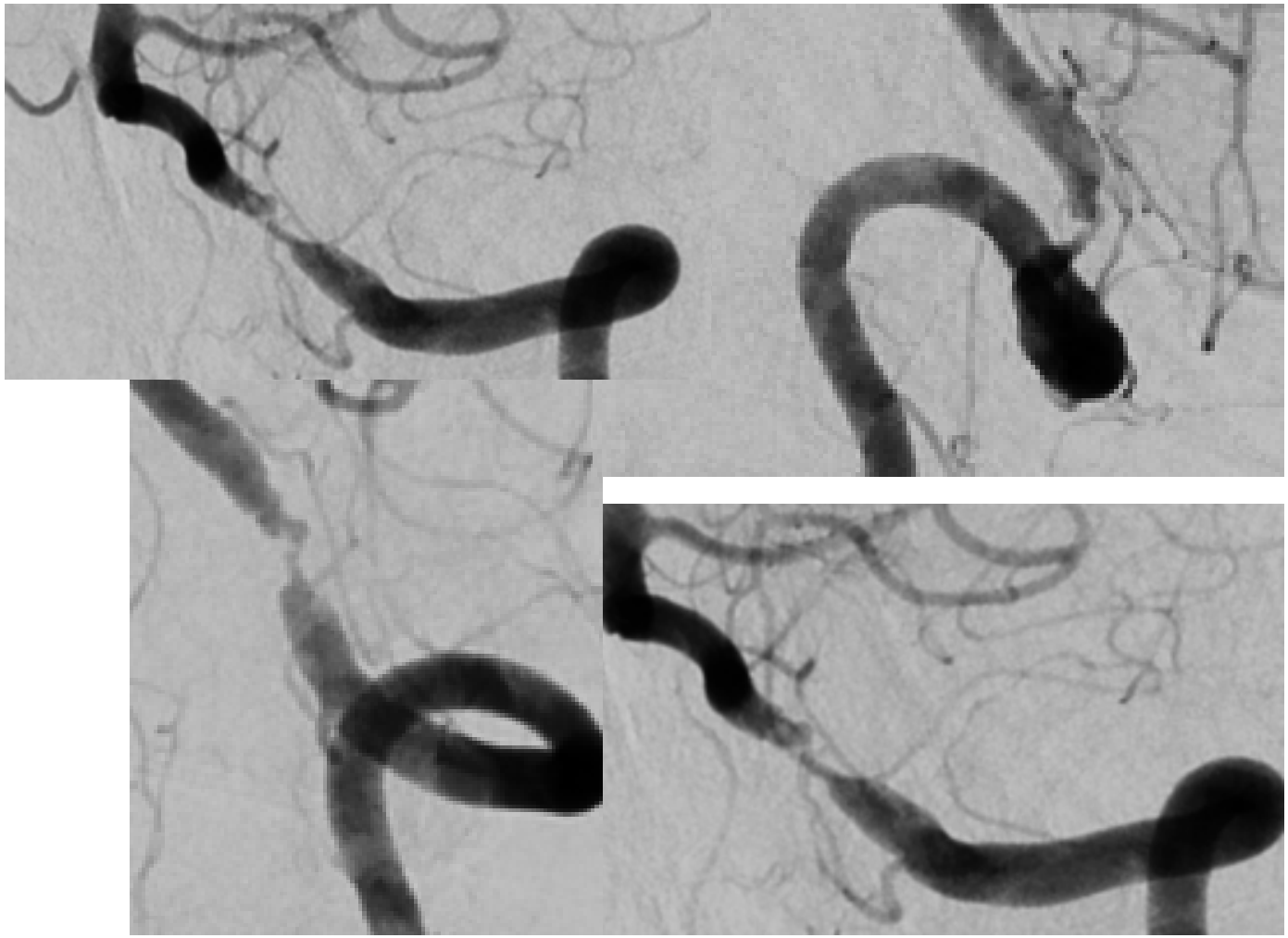
Clinical Neurology and Neurosurgery

journal homepage: www.elsevier.com/locate/clineuro

Stenting for symptomatic intracranial vertebrobasilar artery stenosis: 30-day results in a high-volume stroke center

Lian Liu[a], Xiaojing Zhao[b], Dapeng Mo[a], Ning Ma[a], Feng Gao[a], Zhongrong Miao[a,*]

[a] Department of Interventional Neuroradiology, Beijing Tiantan Hospital, Capital Medical University, China National Clinical Research Center for Neurological Diseases, Center of Stroke, Beijing Institute for Brain Disorders, Beijing, China
[b] The Catheterization Room of Interventional Therapy, The 3rd People's Hospital of Liaocheng, Shandong, China



2.1. Endovascular technique

The procedures were mostly performed under general anesthesia with intubation. However, if the access was smooth and less procedural time was expected, the procedure would be carried out under local anesthesia alone. All patients received systemic

(according to the diameter of the target vertebral artery) Envoy guiding catheter (Cordis, Florida, USA) was placed into the distal V2 segment of vertebral artery at about C4–C2 level. If it is difficult to reach the target vessel via the transfemoral approach, the transradial approach was used instead. The degree of stenosis was calculated in relation to the adjacent distal normal vessel diameter (WASID criteria), and calibration of the measurements performed with the contrast-filled guiding catheter used as the reference, or measured by the DSA workstation.

Device selection by the Wingspan or the Apollo stent depends on arterial access and lesion morphology. From our experience, the Gateway–Wingspan system is more suited to patients with tortuous vascular access, as this system has better flexibility in traversing curvatures. The Apollo stent is more rigid compared with the Gateway–Wingspan system, but it is preferred for patients with smoother access, as the delivery of this balloon-expandable stent does not require exchanging and less procedural time is needed. Hence, for patients with smooth arterial access and Mori A lesion, the balloon-mounted stent would be preferred. For patients with tortuous arterial access and a Mori B or C lesion, or a lesion with a significant mismatch in the diameter between proximal and distal segment, Gateway balloon plus Wingspan stent system is preferred. If perforator arteries originated near the stenotic site, the Gateway–Wingspan system is also preferred, because balloon-mounted stents are considered to result in perforator strokes more easily. If the Gateway–Wingspan system was selected, the stenotic site would be submaximally predilated by Gateway balloon before Wingspan stent deployment, and the recommended Gateway balloon diameter (when inflated at the nominal pressure of 6 atm) was 80% of the native vessel diameter. As per the original design, the balloon mounted stent was done without predilation. For Wingspan stent, size selection was based on the native diameter of the target vessel and length of the stenotic lesion (deployed stent to extend at least 3 mm on either side of the lesion). For Apollo stent, the stent diameter was selected to be the same as the diameter of the normal adjacent vessel (on either side of the stenosis, whichever was smaller) or slightly smaller (1:1 or 0.9:1), and the stent length was 1–2 mm longer than the target lesion on both sides.

After deployment of the stent, an angiogram of the access vertebral artery was performed immediately to measure the residual stenosis. All procedures were conducted by skilled neurointerventionalists (MZR, MN, MDP and GF).

2.2. Pre-/post procedure medical management

The regimen for aggressive risk factor control was based on the SAMMPRIS study and the Chinese ischemic stroke guideline [6]: aspirin (100 mg/day) + clopidogrel (75 mg/day) for more than 5 days before the operation; Nimodipine administered intravenously 2 h before stenting (please check) for preventing vasospasm. Cerebral computed tomography (CT) scan was performed to look for possible intracranial hemorrhage immediately after stenting. Aspirin (100 mg/day) and clopidogrel (75 mg/day) was given for 90 days post-stenting and lifelong aspirin 100 mg/day was continued thereafter. Subcutaneous low-molecular-weight heparin was given for 3 days if the immediate CT scan showed no intracranial hemorrhage. For vascular risk factor control, the aim is for a target systolic blood pressure of <140 mm Hg (or <130 mm Hg in patients with diabetes), low-density lipoprotein <70 mg/dL (1.81 mmol/L) or a decrease by 50%, smoking cessation and lifestyle modification for obesity and sedentary state.

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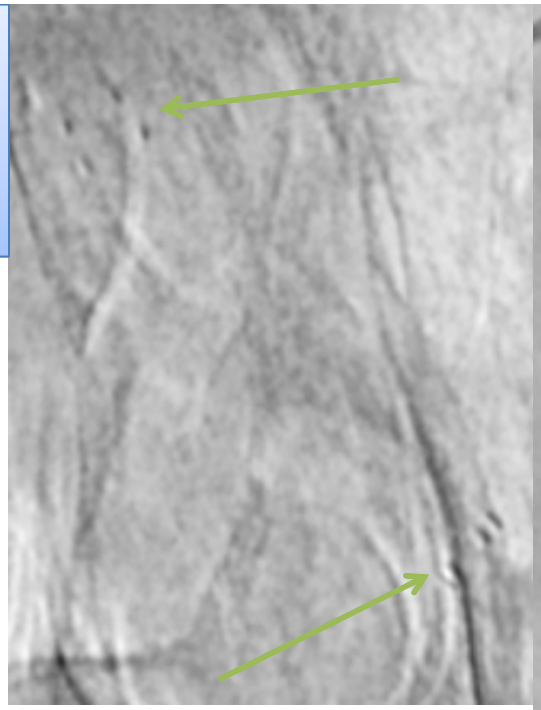
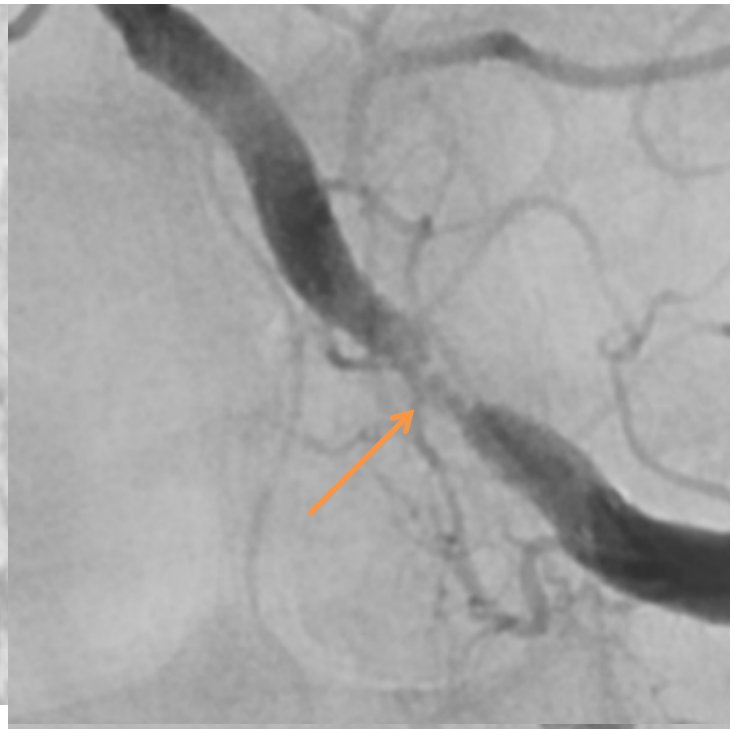
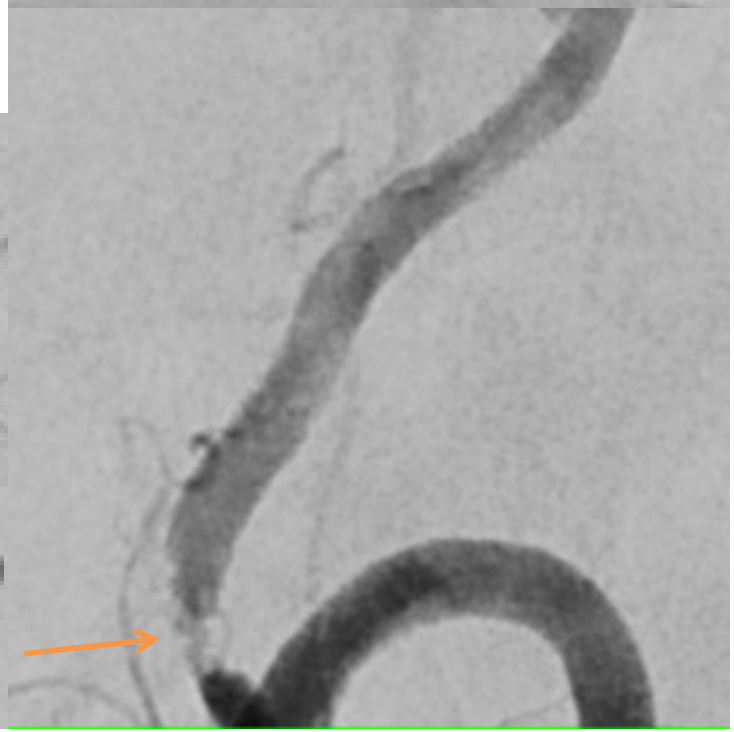
Estenosis de la arteria vertebral, de bordes irregulares, corta, arterioesclerótica sin calcificación parietal.(negra)
Angioplastia con balón gateway y stent Wingspan 3mm x 20 mm.(flecha verde)
En series angiográficas de control, trombosis intrastent.(naranja)







En el tratamiento de la trombosis intrastent, se realiza aspiración y angioplastia.
Se obtiene una reapertura del vaso ocluido con un calibre satisfactorio y sin la presencia de fenómenos tromboembólicos distales