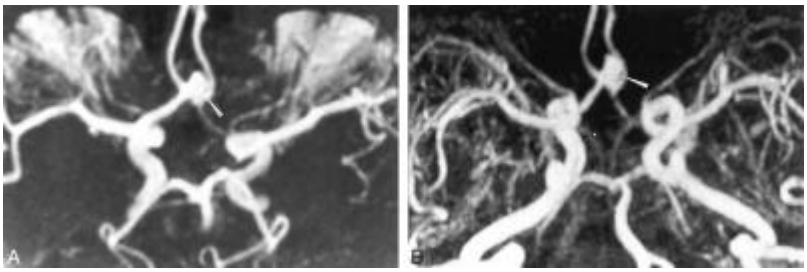
Anterior communicating artery aneurysm

J.Sales-Llopis

Neurosurgery Service,General University Hospital Alicante, Spain.



Latest PubMed Articles

- THSD1 Is a Multifaceted Regulator in Health and Disease
- Elevated Expression of TGFB1 in PBMCs Is Associated with Intracranial Aneurysm Formation, but TGFB3 Expression Implicated Rupture
- Worthwhile or Not? The Pain-Gain Ratio of Screening Routine cMRIs in a Maximum Care University Hospital for Incidental Intracranial Aneurysms Using Artificial Intelligence
- Non-Saccular Aneurysm Shape as a Poor Prognostic Factor in Younger Patients with Spontaneous Subarachnoid Hemorrhage
- Histological Analysis of Intracranial Cerebral Arteries for Elastin Thickness, Wall Thickness, and Vessel Diameters: An Atlas for Computational Modeling and a Proposed Predictive Multivariable Model of Elastin Thickness
- Risk Factors for Unfavorable Angiographic Outcomes after Reconstructive Endovascular Treatments of Unruptured Vertebral Artery Dissecting Aneurysms
- Intracranial Aneurysm Predisposing to Terson's Syndrome: Insights From a Systematic Review
- A Case of a Non-giant Intracranial Aneurysm with Spontaneous Occlusion Directly Observed during Clipping Surgery

Definition

An anterior communicating artery aneurysm is a intracranial aneurysm localized, abnormal dilation or ballooning of the anterior communicating artery.

Epidemiology

see Anterior communicating artery aneurysm epidemiology.

Classification

see Anterior communicating artery aneurysm classification.

Risk Factors

see Anterior communicating artery aneurysm risk factors.

Clinical features

see Anterior communicating artery aneurysm clinical features.

Diagnosis

Anterior communicating artery aneurysm diagnosis.

Management

The management of an anterior communicating artery (ACoA) aneurysm involves a multidisciplinary approach and may include medical, endovascular, or surgical interventions. The specific treatment plan depends on various factors, including the size and location of the aneurysm, the patient's overall health, and the presence of any symptoms.

Treatment

see Anterior communicating artery aneurysm treatment.

Outcome

see Anterior communicating artery aneurysm outcome.

Complications

see Ruptured anterior communicating artery aneurysm

see Hydrocephalus after aneurysmal subarachnoid hemorrhage

Case series

see Anterior communicating artery aneurysm case series.

Case reports

Anterior communicating artery aneurysm case reports.

Case reports from the General University Hospital, Alicante

Microsurgical clipping of an incidental anterior communicating artery aneurysm in a multimorbid elderly patient case report and clinical reflections

Q11597

A 44-year-old patient arrives at the Emergency Department brought in by the Emergency Medical Service (SAMU) following a deterioration in the level of consciousness at home. Apparently, they were found at the foot of the bed with sphincter relaxation. Their companions (not present during the examination) were able to lift them onto the bed, and SAMU was called. On assessment, the patient has a Glasgow Coma Scale (GCS) score of 13, along with hypertensive crisis, and is brought in receiving Urapidil 50 mg + 50 mg in infusion.

Vital signs:

Blood pressure: 190/98 mmHg Heart rate: 80 beats per minute Oxygen saturation (SpO2): 98% (ambient air) Neurological examination according to the Glasgow Coma Scale:

Eye opening (E): 2 Verbal response (V): 2 Motor response (M): 5 Total score: 9

Extensive subarachnoid hemorrhage distributed throughout perimesencephalic cisterns (predominantly in the chiasmatic cistern), prepontine cistern, both Sylvian fissures, and interhemispheric fissure, with a component of bifrontal parasagittal intraparenchymal hematoma with mild adjacent vasogenic edema. The hemorrhage also extends into the ventricular system (third ventricle and lateral ventricles). Findings consistent with modified Fisher grade IV subarachnoid hemorrhage.

This extension is compatible with an aneurysmal subarachnoid hemorrhage pattern.

Erasure of cerebral sulci, predominantly frontotemporal, in relation to diffuse cerebral edema.

Increased ventricular size for the patient's age.