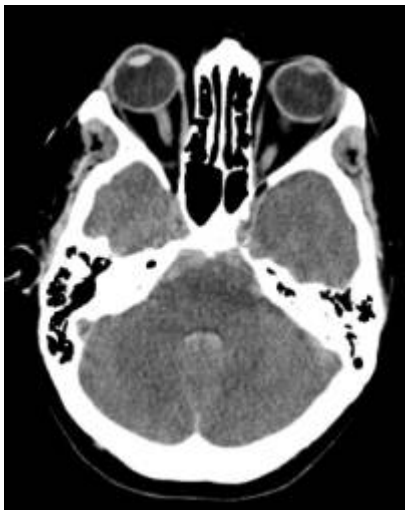
Anterior spinal artery aneurysm case reports

A 53-year-old woman, with a history of Systemic lupus erythematosus (SLE) and secondary antiphospholipid syndrome (APS). Deep-Vein Thrombosis and ischemic colitis, left hemicolectomy. On treatment with oral prednisone, IV belimumab (last dose March 2020), Hydroxychloroquine, Acenocoumarol.

She developed acute onset of epigastralgia due to possible intestinal vasculitis, began treatment with corticosteroids, without improvement in abdominal pain.

The patient started with headache and was diagnosed with subarachnoid hemorrhage.



2021

A 64-year-old man presented with subarachnoid hemorrhage from a ruptured anterior spinal artery aneurysm at the C1 level. Following initial conservative management, surgical treatment was proposed owing to an increase in lesion size at angiographic follow-up. A partially thrombosed aneurysm was found during surgery, suggesting that spontaneous resolution of the aneurysm was occurring. Despite initial worsening of neurological symptoms, the patient gradually recovered after rehabilitation.

Conclusions: Treatment decisions for spinal aneurysms should be made on a case-by-case basis, the goal being to offer the patient the best option, while avoiding exposure to unnecessary invasive procedures. As spontaneous resolution of a spinal artery aneurysm is unpredictable, our case highlights the importance of performing a perioperative vascular study if surgery is planned.

2020

Cobb et al. presented the first case to date of a ruptured anterior spinal artery aneurysm with clinical and radiographic progression treated with Onyx embolization. THe patient was unique in the presentation with acute onset of spinal cord injury American Spinal Injury Association Impairment Scale B and an extensive thoracolumbar spinal subdural hematoma.

An emergent skip-level laminectomy and subdural decompression were performed with no improvement in examination. This was followed by progressive radiographic enlargement of the aneurysm, treated successfully with Onyx embolization.

They analyzed this case and review the literature on thoracic anterior spinal artery and artery of Adamkiewicz aneurysms [1].

2019

A 77-year-old patient with subarachnoid hemorrhage had a dural arteriovenous fistula located at the C1-C2 level. Left vertebral angiography showed a fistula between the left C2 radiculomeningeal artery and perivertebral plexus. Furthermore, right vertebral angiography showed a ruptured aneurysm at the aberrant branch of the anterior spinal artery originating from the contralateral vertebral artery (VA), possibly formed because of the concurrently increased pressure of the perimedullary veins. Aneurysm extirpation was planned through a posterolateral approach. To reduce venous bleeding during the approach, preoperative embolization of the radiculomeningeal muscular artery was performed. During surgery, the suboccipital triangle was exposed following layer-by-layer dissection of the suboccipital muscles.

Subperiosteal dissection of the paravertebral plexus surrounding the VA around the C1 lamina was effective to avoid venous bleeding. A bloodless operative field was achieved, and key anatomical structures, such as the C2 nerve root, feeder, and V3 portion of the left VA, were clearly identified. With a sufficient amount of lateral exposure, the ruptured anterior spinal artery aneurysm was successfully extirpated with bipolar coagulation. The patient was discharged with no neurologic deficit.

Controlling extradural venous congestion is essential to obtain a clear operative field in cases of arteriovenous shunt disease at the craniovertebral junction. The link to the video can be found at: https://youtu.be/fCT69WtAQbo . [2].

A patient with polyarteritis nodosa and spinal subarachnoid hemorrhage following rupture of an anterior spinal artery aneurysm. Following operative washout and decompression of the subarachnoid hemorrhage, spinal digital subtraction angiography was performed and revealed intimal contour irregularities, stenotic changes, and multiple small aneurysms in renal, hepatic, and bronchial arteries and some proximal spinal arteries, and, most notably, a pseudoaneurysm of the anterior spinal artery supplied directly by the artery of Adamkiewicz. Polyarteritis nodosa was subsequently diagnosed in light of these findings. Though previous cases have noted spinal subarachnoid hemorrhage in of the context of polyarteritis nodosa, they found no previously documented case of a definitive aneurysm of the anterior spinal artery in a case of polyarteritis nodosa documented on angiography. This case highlights the potential importance of monitoring for aneurysms of the spinal vasculature in cases of polyarteritis nodosa and in screening for vasculitides in cases of spinal subarachnoid hemorrhage. Future studies are needed to describe patterns of the specific anatomic localization and incidence of spinal artery aneurysms in polyarteritis nodosa [3].

A 78-year-old man with a craniocervical junction epidural arteriovenous fistula who presented with subarachnoid hemorrhage from a ruptured anterior spinal artery (ASA) aneurysm. Because endovascular embolization was difficult, a posterolateral approach was chosen and a novel endoscopic fluorescence imaging system was utilized to clip the aneurysm. The fluorescence imaging system provided clear and magnified views of the ventral spinal cord simultaneously with the endoscope-integrated indocyanine green videoangiography, which helped safely obliterate the ASA aneurysm. With the aid of this novel imaging system, surgeons can appreciate and manipulate complex vascular pathologies of the ventral spinal cord through a posterolateral approach, even when the lesion is closely related to the ASA [4].

2018

Ruptured Fusiform Aneurysm of the Anterior Spinal Artery : Successful Treatment with Flow Diverter Stent Placed in the Feeding Vertebral Artery [5].

2017

Isolated aneurysms of spinal arteries are rare. Spinal artery aneurysms are commonly found in association with spinal arteriovenous malformation and coarctation of the aorta and rarely with aortic arch interruption and Klippel-Trenaunay syndrome. Spinal angiograms are the gold standard for diagnosing these spinal artery aneurysms but with the advances in computed tomography technology these aneurysms can also be very well demonstrated in computed tomography angiograms. Sing et al. described three cases of anterior spinal artery aneurysm, those are flow related aneurysms, associated with coarctation of aorta and with Takayasu's arteritis [6].

Anterior spinal artery aneurysms (ASAA) are extremely rare. While these aneurysms are very well known to cause spinal subarachnoid haemorrhage/hematomyelia secondary to sudden rupture, presentation with chronic myelopathy remains extremely rare.

A 50-year-old gentleman presented with chronic upper thoracic myelopathy for 1 year. MRI of the dorsal spine revealed an intradural T2 hypointense mass with prominent vessels at T1 level. During intra-arterial angiography, accidental diagnosis of a co-existent co-arctation of the aorta was made. The intradural spinal mass turned out to be a giant, partially thrombosed ASA aneurysm on angiography. This patient underwent surgical clipping of the aneurysm utilizing a posterolateral approach. The patient experienced a stormy early postoperative period due to acute renal failure and pulmonary edema that settled down by the time of discharge.

ASAA remains an extremely rare cause of compressive myelopathy. Its association with co-arctation of aorta increases treatment related mortality. Posterolateral approach provides a good exposure of the aneurysm for surgical clipping with minimal retraction of the cord [7].

2014

Two cases presenting with spinal subarachnoid haemorrhage that underwent conservative

management. In the first patient the radiculomedullary branch involved was feeding the anterior spinal artery at the level of D3 and thus, neither endovascular nor surgical approach was employed. Control angiography was performed at seven days and at three months, demonstrating complete resolution of the lesion. In our second case, neither the anterior spinal artery or the artery of Adamkiewicz could be identified during angiography, thus endovascular management was deemed contraindicated. Magnetic resonance imaging showed a stable lesion in the second patient. No rebleeding or other complications were seen. In comparison to intracranial aneurysms, spinal artery aneurysms tend to display a fusiform appearance and lack a clear neck in relation to the likely dissecting nature of the lesions. Due to the small number of cases reported, the natural history of these lesions is not well known making it difficult to establish the optimal treatment approach. Various management strategies may be supported, including surgical and endovascular treatment, but It would seem that a wait and see approach is also viable, with control angiogram and treatment decisions based on the evolution of the lesion. [8)].

2007

A 12-year-old boy with spinal cord arteriovenous malformation (AVM) and an associated anterior spinal artery (ASA) aneurysm treated with selective coil placement in the context of subarachnoid hemorrhage (SAH). The patient presented with headache. Head computed tomography scanning revealed no abnormal findings. The cerebrospinal fluid was sampled and analyzed and a diagnosis of SAH was established. Investigation, including magnetic resonance imaging of the cord as well as cerebral and spinal angiography, revealed a conus medullaris AVM and a saccular aneurysm located on the ASA at the T-11 level. The aneurysm was thought to be responsible for the bleeding. Superselective ASA angiography showed that the aneurysm was at the bifurcation between a large coronal artery supplying the AVM and the ASA. The relation of the aneurysm's neck to the main spinal axis and the aneurysm's morphological features indicated that the lesion was suited for endosaccular coil therapy. The aneurysm was selectively occluded, using electrodetachable bare platinum coils. Follow-up angiography immediately after surgery and at 6 months thereafter demonstrated complete occlusion of the aneurysm and a perfectly patent anterior spinal axis. On clinical follow-up examination, the patient remained neurologically intact. When the morphological features of a spinal aneurysm and its relation with the anterior spinal axis are favorable, selective endosaccular coil placement can successfully be achieved [9)].

1999

A 42-year-old man with a ruptured anterior spinal artery aneurysm is presented here. He experienced subarachnoid hemorrhage, which was confirmed by computed tomography. Magnetic resonance imaging revealed an aneurysm in front of the upper part of the medulla. Angiography demonstrated bilateral vertebral artery occlusion. Distal vertebral arteries and the basilar artery were perfused via the dilated anterior spinal artery, which originates in the right subclavian artery. The aneurysm was located at the distal part of the anterior spinal artery, and was successfully clipped through a lateral suboccipital craniotomy 2 months after bleeding from the aneurysm. After rehabilitation, the patient was able to walk with no apparent neurologic deficit.

This case suggests that the anterior spinal artery as a collateral route after bilateral vertebral artery occlusion is under hemodynamic stress, resulting in aneurysm formation and rupture [10)].

1981

A woman who presented with a subarachnoid hemorrhage secondary to a ruptured anterior spinal artery aneurysm of the spinal cord is reported. While this is the first report of a ruptured aneurysm of the anterior spinal artery with angiographic confirmation, it emphasizes that occasionally subarachnoid hemorrhage may be secondary to ruptured spinal artery aneurysms [11)].

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