Case report

Coil embolization of ruptured frontopolar artery aneurysm: Case report

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ABSTRACT

Distal anterior cerebral artery aneurysms are infrequent. The most common location is at the bifurcation of the pericallosal and callosomarginal arteries. Cerebral artery anomalies can sometimes, at least partially, explain aneurysm formation in less common locations in relation to hemodynamic stress caused on the vascular wall. We report a very rare case of subarachnoid hemorrhage due to a ruptured frontopolar artery aneurysm as a part of an anomalous anterior cerebral artery complex that was, for the first time, treated with endovascular coiling.

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Tratamiento endovascular de aneurisma roto en arteria frontopolar: caso clínico

RESUMEN

Los aneurismas distribuidos distalmente en la circulación cerebral anterior son infrecuentes. La localización más habitual dentro de este tipo de aneurismas es la bifurcación entre las arterias pericallosa y callosomarginal. Las variantes anatómicas vasculares cerebrales pueden explicar, al menos en parte, la formación de aneurismas en localizaciones menos comunes en relación al estrés hemodinámico que ocasionan en la pared vascular. Describimos un caso infrecuente de hemorragia subaracnoidea debida a la rotura de un aneurisma en la arteria frontopolar y que forma parte de una variante anómala del complejo de la arteria cerebral anterior que ha sido por primera vez manejada mediante tratamiento endovascular.

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Introduction

Distal anterior cerebral artery (DACA) aneurysms are those located after anterior communicating artery, also known as pericallosal artery aneurysms. The incidence of saccular aneurysms in DACA is low, representing about 6% (range 2–9%) of all intracranial aneurysms. The most common location of DACA aneurysms is the A3 segment, accounting for approximately 69–82% of all DACA aneurysms, especially at the bifurcation of the pericallosal (PCA) and callosomarginal (CMA) arteries. Frontopolar artery (FPA) aneurysms are much less frequent, with a few cases reported in the literature. Changes in hemodynamic stress that potentiate aneurysm development are seen in relation to anatomical variations of cerebral arteries branching and radii. In the present case, the presence of the aneurysm was associated to an anatomical variation of the anterior cerebral artery complex, possibly contributing to the formation of an aneurysm in this infrequent location. Surgical treatment has been reported as the principal modality of treatment in these distal aneurysms. This article describes the first case of a saccular aneurysm originating from an anomalous FPA treated with endovascular coiling and discusses the difficulties regarding treatment of aneurysms in this unusual location.

Case report

A 55-year-old woman was admitted after experiencing acute loss of consciousness and tonic-clonic seizure at home. Her past medical history included hepatitis B infection, alcohol abuse and residual schizophrenia. There was no past history of hypertension, smoking, other drug abuse, SNC infection or trauma. On admission, the initial examination showed an unconscious patient (GCS 3) with reactive miotic pupils that diverged to the right (Hunt & Hess classification grade 5, World Federation of Neurosurgeons grade 5). After stabilization, a computerized tomographic (CT) scan was performed (Fig. 1) showing parasagittal frontal subarachnoid hemorrhage and bilateral frontobasal intracerebral hematoma (ICH) opened to the ventricular system (Fisher III). Moderate dilatation of the ventricles also appeared as a sign of acute hydrocephalus. AngioCT scan detected an aneurysm arising from right FPA and signs of vasospasm in both ACAs. Before angiography was performed, an external ventricular drainage was placed. Angiography (Fig. 2A, C and E) revealed a saccular aneurysm of 5 mm diameter, with a neck of 3 mm, at the origin of a right atypical FPA. The anatomical variation of right DACA consisted in FPA arising from the CMA trunk originated from the A2 segment. Right CMA seems to be larger than the PCA after their bifurcation. There was also an associated aneurysm at anterior communicating artery (AComA) of 1.4 mm of main diameter that did not show signs of recent bleeding. After selective microcatheterization of the FPA aneurysm, it was completely obliterated with 2 coils (Fig. 2B, D and F) maintaining the distal arterial lumen totally permeable. During her hospitalization a ventriculoperitoneal shunt was placed due to chronic hydrocephalus. Nowadays, the patient is at home and is orientated, able to keep a sensible conversation and walking.

Discussion

DACA aneurysms are very infrequent, comprising about 6% (range 2–9%) of all intracranial aneurysms in different series. Among DACA aneurysms, A3 segment aneurysms are the most frequent with an incidence of 69–82%, especially at the CMA–PCA junction. Much more infrequent, A2 segment aneurysms (A2A) have a reported incidence about 5–22% of all DACA aneurysms. They can appear at the main A2 trunk or on its frontobasal branches. Lehecka et al. found in their 35-A2A patients series that the most frequent location of A2A is on the A2 trunk at the origin of the FPA. Few FPA aneurysms have been reported and, up to our knowledge, only eight cases of aneurysms of the FPA, when it arises from CMA have been previously described.

Although aneurysm pathogenesis is not completely understood, congenital variations in the circle of Willis can predispose to the formation of saccular aneurysms due to an increased in hemodynamic stress. Deviation from optimal geometrical parameters (radii, branch and bifurcation angles) creates areas of abnormal wall shear stress level that leads to endothelial injury and a wrong remodeling response that finally initiates aneurysm development. Consistently, a higher incidence of vascular variations in clinical series of patients harboring aneurysms in comparison with anatomic studies without aneurysms has been reported.

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Fig. 1 – Initial axial CT scan, demonstrating parasagittal frontal subarachnoid hemorrhage and bilateral frontobasal intracerebral hematoma opened to the ventricular system with signs of acute hydrocephalus.
Lehecka et al. in their angiographic analysis of patients with DACA aneurysms found that the most common vascular variation was bihemispheric ACA with an incidence of 15% followed by azygos ACA and triplication of ACA. The anatomical variations between FPA, CMA and PCA are rare. The most common DACA complex consists in OFA and FPA arising directly from A2 segment with CMA–PCA bifurcation located in A3 segment. Distribution of distal branches is less constant (Fig. 3A). FPA branching from CMA has been described in 9% of the hemispheres examined. In relation to vessel diameter, CMA can have greater diameter than PCA in 44% of cases, the PCA being larger in 23% and the FPA of greatest diameter in 9%. CMA and PCA have the same diameter in the rest 34% of cases. The anatomical variation of the case that we describe consists in a right CMA–PCA bifurcation located at A2 segment with a CMA trunk that gives origin to FPA, AIFA and middle internal frontal artery (MIFA) (Fig. 3B). CMA trunk seems to show a greater diameter than PCA. Here we report an infrequent aneurysm location and we suggest that it can be, at least, partially explained by the influence of the

Fig. 2 – Anteroposterior (A), lateral (C) and detail (E) views of right carotid angiogram obtained before embolization showing an aneurysm in the right FPA. As a part of anterior cerebral artery complex variation, right FPA arises from the CMA trunk with origin in the A2 segment. Post-embolization right carotid angiogram, anteroposterior (B), lateral (D) and detail (F) views demonstrating a complete aneurysm obliteration and distal arterial lumen totally permeable.

Fig. 3 – Anatomic diagrams of vascular patterns of DACA. Most frequently described configuration (A) consists in FPA arising directly from A2 segment with CMA–PCA bifurcation located in A3 segment. PCA has greater diameter than CMA. Present case vascular variation (B) involves right CMA–PCA bifurcation located at A2 segment with a CMA trunk that gives origin to FPA, AIFA and MIFA. CMA showed greater diameter than PCA.
Conclusions

This report shows the importance of a cautious review of vascular studies in the case a vascular variation is found in order to exclude aneurysms in less common locations. When distal FPA aneurysm characteristics allow coil embolization, endovascular management can be considered a feasible and safe option.

REFERENCES