We present the case of a 22-year old male patient with no history of interest, who attended consultation due to holocranial headache, with no nausea, vomiting, photophobia or focality, of 6 months’ duration. The patient also presented rhinorrhoea and night time snoring. The otoneuro-laryngological examination was normal except for bilateral papillary oedema and palpebral ptosis.

A cranial CT scan showed a soft tissue mass, which affected the right petrous apex and cavernous sinus, causing destruction and insufflation of the right side of the base of the skull. Occupation of the right mastoid was also observed (Fig. 1). Cranial MRI: intrapetrous and intracavernous carotid aneurysm of 3.8 × 3 × 3.7 cm (Fig. 2). MR Angiography (MRA): partially thrombosed ICA aneurysm (Fig. 3). The patient was referred to neurosurgery, where an embolization by endovascular carotid occlusion was carried out.

Aneurysm of the internal carotid at intrapetrous level is extremely rare. Its clinical presentation, which depends on the direction of its expansion, ranges from non-abnormal to

![Figure 1](http://www.elsevier.es/otorrino)
Giant Petrous Carotid Aneurysm

Figure 2

to headache, cranial nerve palsies (third to sixth), epistaxis, hearing loss, tinnitus, etc. On occasions, endoscopy can reveal a polyp in the sphenoethmoidal recess.

This entity is usually diagnosed as a radiographic finding, through CT plus MRI, and MRA confirms the vascular nature of the lesion. Differential diagnosis must be carried out with cholesterol granuloma, jugulotympanic glomus tumour, high jugular bulb and aberrant carotid artery.

Treatment must be individualised. As this aneurism is located in a surgically inaccessible area, endovascular occlusion or ligation of the internal carotid artery must be performed.

Figure 3