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POSTER

Floating carotid plaque thrombus: a case of watchful waiting approach

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Abstract

The patient was a 51-year-old female university professor, with history of smoking, C7-D1 disc hernia surgery in 2014 and two episodes of right hemiparesis in November 2016 – interpreted as transient ischemic attacks – and under oral antiplatelet since.

In February 2017, the patient had acute onset of dysarthria and left hemiparesis. In this context, the Stroke Code (Via Verde AVC) was activated. At hospital admission, the patient was conscious, without dysarthria or language deficits, facial asymmetry, visual field defects or ophthalmoparesis. She had a mild right hand paresis, but no associated sensitive deficits. Her NIHSS score was 2. Even before the brain computed tomography (CT) was performed, right hand strength was recovered. Head CT showed no acute parenchymal lesions. AngioCT of the supra-aortic vessel depicted a severe post-bulbar stenosis of the left internal carotid artery (ICA) over a short segment and was suggestive of an associated luminal thrombus.

Despite the severe carotid stenosis, no intravenous fibrinolysis was administered, given the low NIHSS score. It was also decided not to perform any endovascular procedures at that time and the patient was admitted to a stroke unit for further vascular workup and vigilance.

Carotid ultrasound study confirmed the endoluminal thrombus with oscillatory movements in the origin of the left ICA and the hemodynamic study was compatible with a severe stenosis of the proximal segment of the artery. Given these findings, it was decided to maintain the patient on an oral antiplatelet and start anticoagulation with enoxaparin, with posterior bridging to warfarin.

Brain magnetic resonance imaging showed small acute ischemic lesions on the left: in the posterior frontal white matter, corona radiata and transition between the caudate head and body. Serial carotid ultrasound studies showed complete resolution of the thrombus, with a persistent atherosclerotic stenosis of 50-60%.

The patient had a favorable clinical evolution, with a NIHSS score of 0 at hospital discharge.

Diagnosis at discharge was atherosclerotic acute ischemic stroke.

Conclusion: The doubt persists - was watchful best medical treatment indeed the best option, or would acute phase thrombectomy have been a better one?

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