A horse with stripes—the importance of clinical-radiological correlation

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Abstract

Introduction: Increasing evidence favours the benefits of thrombectomy and amidst its growing practice, proper clinical assessment and successful bridging between specialties is as important as ever.

Case report: A 79-year old male with modified Rankin Scale of 0, multiple vascular risk factors, ischemic cardiopathy, history of acute myocardial infarction (AMI), heart failure, peripheral artery disease and implantable cardioverter defibrillator was admitted after acute pulmonary oedema following cardiogenic shock secondary to another AMI. Cardiac catheterization was performed, during which he reportedly went into coma. The patient was rushed to the emergency department and the possibility of vertebrobasilar insufficiency prompted a cerebral CT scan, without proper neurological assessment. The CT scan showed no signs of cerebral infarction. There was, however, increased mean transit time in the area supplied by the right middle cerebral artery (MCA) with corresponding "arterial stop" sign on its M1 segment. Neurological examination done afterwards revealed fluctuations of awareness and tetraparesis with right-sided dominance. Despite clinical-radiological mismatch, the patient was nonetheless taken for thrombectomy. Angiography revealed several irregularities along the internal carotid and vertebral arteries, as well as what ended up being a chronic stenosis in the M1 segment of the MCA with local neovascularization and collateral flow via posterior circulation. No further endovascular action was performed.

Conclusion: We present the case of a seemingly classical thrombectomy candidate, except it lacked the most important variable - clinical reasoning. Teamwork between specialties and joint effort in assessing the context should always be a premise in medical care.