



ORAL PRESENTATION

Vertebral dissection with distal occlusion—where to start?

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Abstract

Vertebral artery (VA) dissection is a rare but relevant cause of stroke especially in young patients. Treatment strategy depends on several factors such as timing, location and extent of the disease. A 61-year-old man presented with a 2-hour history of non-fluent aphasia. The patient was somnolent, and the exam revealed naming impairment, left ptosis, slight abduction of the left eye, right central facial paralysis and right arm paresis. Cranial CT showed no signs of acute ischemia. CT angiography revealed a right VA proximal stenosis, a V2 segment filling defect and distal occlusion of the top of the Basilar Artery (BA) extending to the left Posterior Cerebral Artery. Mechanical thrombectomy (MT) was attempted by the left VA. After 2 passes, control angiogram revealed extended occlusion to the proximal BA. The right VA was then catheterized, distal MT was performed, and a

stent was deployed on the right V1 segment. Control angiogram showed patency of the stent but persistent occlusion of the top of the BA. As a microcatheter could not progress through the stent, MT was then again performed by the left VA. After the procedure MRI excluded acute ischemic lesions of the brainstem or thalamus. The patient recovered most of the deficits and was kept on dual antiplatelet therapy. VA dissections with distal occlusion are challenging cases. Stenting in the acute phase is controversial as most dissections heal spontaneously and thrombus formation can be prevented with antiplatelets. This case stresses the importance of evaluating the diseased VA before delineating your strategy and also the necessity to recanalize highly thrombogenic dissections in the acute setting.

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