

# **BASILIAR ARTERY TROMBECTOMY 24 HOURS AFTER THE ONSET OF SYMPTOMS**

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## **HISTORY AND PHYSICAL**

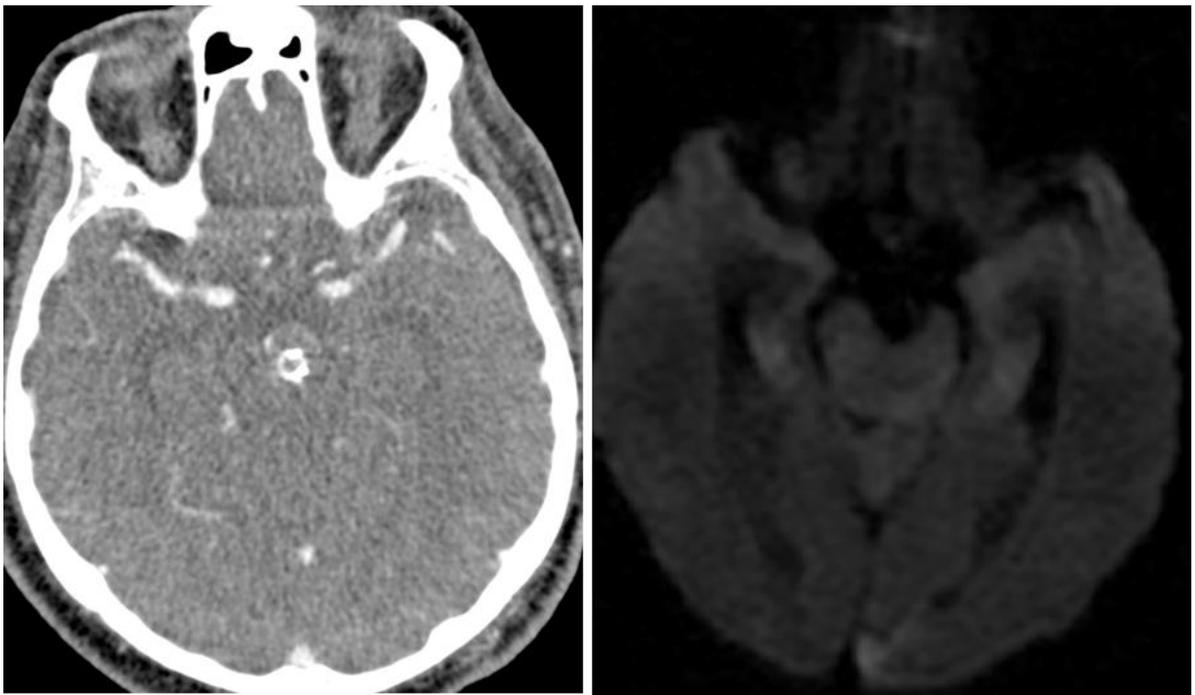
67yo male with fusiform aneurysm of basilar artery, manifested with bulbar syndrome, underwent LEO stent placement in BA as the first stage of planned FDD implantation. He was discharged and followed, but didn't appear for second stage of treatment.

Year later, he was referred to our department from cardiac clinic, when he underwent coronary stenting for ischemic heart disease.

He was unconscious (GCS 7), pupils were midsize and symmetrical with no apparent signs of gaze palsy, he was intubated and CPAP ventilated. According to patient notes he developed those symptoms more than 24 hours prior to admission, during coronary intervention.

CTA revealed BA in-stent occlusion, but no signs of cytotoxic edema in the brainstem and lack of pontine ischemia on diffuse weighted MR images.

## **IMAGING**



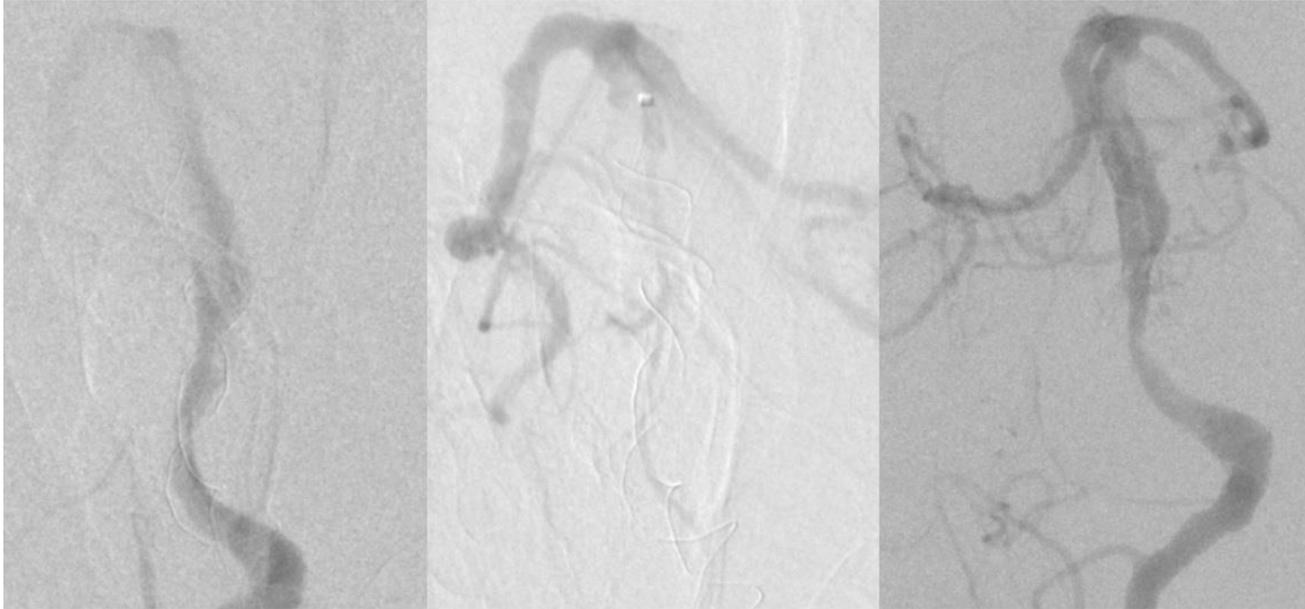
CTA showing BA in-stent occlusion and DWMRI with few signs of pontine ischemia

## **INDICATION FOR INTERVENTION**

Signs of in-stent BA occlusion on CTA with no signs of pontine edema and ischemia.

## **INTERVENTION**

We decided to take risk. Solitaire™ thrombectomy has been performed.



DSA showing stages of thrombectomy

The procedure was performed under the settings of general anesthesia.

The patient retrieved conscious (GCS 14) shortly after the procedure and didn't developed any new symptoms aside from residual bulbar syndrome.

## **LEARNING POINTS OF THE PROCEDURE**

Basilar artery, due to its embryologic and anatomical features, is always a high risk region for thrombectomy. But patients with underlying vascular lesions of the posterior fossa may develop good preconditioning over the course of the disease. Moreover, the fact that patient had fusiform transformation of the basilar artery preserved him from possible drastic complications of thrombectomy, such as rupture of perforant arteries or basilar artery wall.

Said facts, accompanied by insurance limitation, allowed us to take risk, but, in our opinion MRI and CT with perfusion protocols should be performed in cases of prolonged BA occlusion to weight the risk of possible complications.