
RJ Mobbs, KN Chandran
Department of Neuroscience, The Canberra Hospital, Clinical School of the University of Sydney, Woden 2606, ACT, Australia.

Correspondence Address:
R J Mobbs
Department of Neuroscience, The Canberra Hospital, Clinical School of the University of Sydney, Woden 2606, ACT, Australia.

Abstract

Traumatic occlusion of the middle cerebral artery (MCA) is a rare cause of cerebral infarct. We describe a case of MCA occlusion following blunt head trauma. The literature reports some 65 cases of MCA occlusion following non-penetrating blunt trauma to the head. Arterial dissection, cerebral vasospasm and thrombosis have been some of the theories discussed in the pathogenesis of this condition. We review the pathogenesis based on anatomy of the M1 segment.

Introduction

Traumatic occlusion of the middle cerebral artery (MCA) is a rare cause of cerebral infarction. Our research finds a total of 65 cases described in the literature. MCA infarct resulting in death of the patient was encountered in 18 of the reported cases, with a mortality rate of 27%. Arterial dissection is one form of traumatic vascular injury, and from observations reported in the literature, the vertebrobasilar arteries are the most frequently involved, followed by the carotid arteries and their branches.[1] Dissection is usually followed by intramural bleeding with the formation of a haematoma in the dissected space.
Case report

A 15 year old right hand dominant male riding a bicycle fell and hit the road on his left forehead. He was wearing a helmet. He sustained a brief loss of consciousness. On presentation to the emergency department, he became confused, disoriented and combative. Initial head CT and biochemical evaluation was normal. 12 hours following presentation, he was noted to have left sided hemiparesis and was not obeying commands. A Camino (110-4B) intracranial pressure monitor was inserted via a right frontal approach. Initial ICP measurements were between 5-10 mmHg. On day 2, the CT scan noted some mild oedema in the right MCA territory. Cerebral angiography was performed which demonstrated occlusion of the right MCA, several mm from its origin [Figure 1]. Other intra and extra cranial vessels were normal. CT on day 4 demonstrated a right MCA infarct [Figure 2]. ICP readings of 15-22 mmHg were recorded between 2472 hours post injury. Cerebral hypertension was medically managed, and the Camino monitor was removed on day 5, following 24 hours of normal ICP tracings. After 6 weeks of rehabilitation, the patient was mobile with a walking stick.

Discussion

Occlusion of the MCA following blunt head trauma is a rare cause of brain infarction. 65 cases of traumatic MCA occlusion are discussed in the literature; 18 were fatal with a resulting mortality of 27.7%. Many possible pathogenic mechanisms have been discussed.[1],[2],[3],[4],[5],[6],[7],[8],[9],[10],[11],[12],[13],[14],[15],[16] Review of the 18 autopsy cases [Table I] demonstrates that subintimal dissection is the most likely cause of MCA occlusion, noted in 14 out of 18 cases (78%). 2 cases (11%) involved thrombosis in the artery. There was one case of a patent M1 vessel on angiography several weeks following the event and one case from embolus. It can be concluded that the overwhelming likelihood of MCA occlusion following trauma is secondary to intimal dissection, with primary thrombosis and vasospasm as less likely causes.

Many cases were noted following minor head trauma and a relative younger age group (average 28 years). Minimal trauma was involved in our patient and he was young at 15 years. The most common site of occlusion is the origin of the M1 segment (6 out of 14 cases). This may be due to anatomical features of M1. MCA occlusion may have similar pathology as noted in acute rotational injury of the vertebral artery at the C1-C2 region, leading to intramural dissection, haemorrhage and thrombosis.[17] The M1 segment proximally has a firm connection with the skull base at the carotid termination and rotational forces following blunt trauma could lead to tearing of the arterial wall. The M1 segment runs in close proximity to the posterior margin of the sphenoid wing. Impact of this vessel with the sphenoid could result in arterial dissection or intimal damage resulting in thrombosis. Review of 15 normal MRI/MRA scans of patients aged 22 to 82 years was conducted [Table II]. The relative distance of the midpoint of the M1 segment to the sphenoid wing was examined to evaluate the degree of variability in distance. As the table demonstrates, the distance of midpoint MCA to sphenoid ridge varies substantially. On the left side, the closest distance was 5 mm with a maximal distance of 26 mm and an average of 15.5 mm. On the right side, the average mid point distance was 10.6 mm.

Vasospasm as an additional factor in the pathogenesis of MCA occlusion has also been discussed.[5],[9],[11],[18],[19],[20] Spasm following traumatic subarachnoid haemorrhage is most noticeable in the distal portion of the internal carotid artery and the proximal portion of the MCA and ACA.[21],[22],[23] The reported incidence of intracranial arterial spasm following moderate to severe head injury is in the range of 5 to 10%.[22] In a
study of 350 patients with moderate to severe head injury, Suwanela[23] found narrowing of the proximal ACA and MCA in 5.1%, with spasm being found from day 1 to day 19. The role of MRA in the diagnosis of vasospasm was discussed by Yamada et al.[20]

Based on the facts to date, the pathogenesis of traumatic MCA occlusion is primarily due to subintimal dissection and thrombosis. These lesions are due to anatomical and mechanical factors, particular to the M1 segment. In conclusion, these lesions can follow seemingly minimal trauma, be fatal in a young patient population and affect vessels with no underlying abnormality.

References


