Diagnosis of Artery of Percheron Stroke on CT Perfusion

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Abstract

Bilateral medial thalamic strokes are rare and can be caused by an occlusion of the artery of Percheron, an anatomical variant branch off of the posterior cerebral artery. Artery of Percheron (AOP) strokes usually present with general symptoms of hypersonolence, opthalmoplegia and memory impairment, which may show similar features of other conditions and can delay diagnosis. Diagnosing an AOP stroke becomes a challenge due to its small size and ambiguous symptoms, leading to delayed thrombolytic treatment. CT Perfusion (CTP) imaging can be used to detect these small infarcts. The patient in this case was a 94-year-old woman appearing post-surgery who was found to have an AOP stroke discovered only upon CT Perfusion imaging several hours after presentation. Lack of clinical suspicion for this unique syndrome may prevent prompt treatment. A newly defined tPA window of nine hours allows for patients to be treated despite delayed diagnosis, which the patient in our case would have been eligible for. When recognized promptly, patients who present with an AOP stroke may be eligible for Intravenous thrombolysis (IVT) with a good prognosis.

Introduction

The artery of Percheron (AOP) is an uncommon anatomical variant in which a small branch of the posterior cerebral artery (PCA) supplies the bilateral medial thalami, with or without rostral midbrain supply. Estimates for the prevalence of this variant in the population range from 4-11.7% to 30% [1]. AOP strokes are rare, with an estimated prevalence ranging from 0.1-2% of all ischemic stroke patients [1-3]. Small artery disease has been reported to be the most common etiology [2]. When recognized promptly, patients with AOP stroke may be eligible for Intravenous thrombolysis (IVT). Several authors have reported successful thrombolysis of an AOP stroke [4,5].

Patients with an AOP stroke present with a wide array of clinical manifestations including pupillary dilation, hypersonolence, opthalmoplegia (mostly vertical gaze palsy), and rarely memory impairment [2,6,7]. These symptoms may mimic substance intoxication and other neurological syndromes (i.e. Wernicke-Korsakoff syndrome), posing a challenge in clinical diagnosis. Neuroimaging in the acute phase of an AOP stroke may also be non-revealing. The artery of Percheron is very small, averaging 2 mm in diameter [8,9]. One report by Roitberg, et al. identified occlusion of this artery by digital subtraction angiography (DSA) [10]. CT angiography (CTA), however, has limited spatial resolution and is unable to depict an AOP occlusion. Therefore CTA is expected to be normal in most isolated AOP strokes. Diffusion-Weighted Imaging (DWI) and MRI can demonstrate an AOP stroke, however it is not readily available for acute stroke worldwide [1,7]. Subsequent to these clinical and radiological challenges, diagnosis of AOP stroke is commonly made hours to days after symptom onset [7,11], when patients are well beyond the IVT time window.

The ability of CTP source images to demonstrate AOP strokes has been recently reported in several case reports [7,12]. We present here a case of AOP stroke diagnosed by CTP and discuss the therapeutic options for such patients in an extended time window.
This case raises some important points. First, CT perfusion may be used to punctually diagnose these strokes. The ability of CTP source images to demonstrate AOP (bilateral paramedical thalami) strokes has been recently reported in several case reports [7,12] and is demonstrated clearly in our case. CTP imaging from these cases detected increased MTT and decreased cerebral blood flow [12], similar to the findings in our patient.

Another lesson to be learned from our case is that isolated somnolence, without evidence of any suspected causes, and bilateral pupillary abnormalities even without lateralizing signs should arouse the suspicion of AOP stroke, and subsequent MRI or CT imaging is necessary for confirmation.

**Discussion**

Our patient presented with peri-procedural AOP stroke most probably due to a cardioembolic source. Clinical presentation was non-specific, with isolated hypersomnolence that was attributed to procedural sedation. A neurological examination was performed several hours late and showed bilateral mydriasis without further localizing signs. CT and CTA were also non-revealing. Diagnosis of AOP stroke in this patient was only possible after CTP was performed, showing bilateral thalamic and midbrain hypoperfusion foci.

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Perfusion imaging should be promptly performed. Early diagnosis of AOP stroke by CTP allows for prompt IV thrombolysis treatment with complete patient recovery, one case of which has been successfully demonstrated and documented by Ume, et al. [5].

CT perfusion is a functional imaging modality that can produce high-resolution maps of cerebral perfusion. It additionally offers the advantages of a short acquisition time, low cost and increasing availability. The use of CT perfusion for precise depiction of ischemia is becoming more widespread, especially after a recent meta-analysis that showed that IV tPA can be administered in an extended time window up to 9 hours using CTP data [13]. The study suggests that even if the standard 4.5 hours IVT window is missed, patients can still be treated with IVT up to 9 hours as long as CTP does not show a significant infarct core and there is evidence of salvageable brain tissue. Delayed treatment beyond the standard window can still improve functional outcomes, with minimal risk of intracerebral hemorrhage. By these new time criteria, our patient would have been eligible for IVT, potentially preventing any fatal complications.

Conclusion

AOP strokes are rare and diagnosis is challenging, which delays IVT treatment. CTP may offer a reliable method of detecting these strokes more rapidly. A low level of suspicion for this condition in acutely somnolent patients and timely diagnosis may allow for prompt IVT.

References


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