

Spontaneous carotid artery dissection

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A 62-year-old man presented to the emergency department several hours after the onset of disturbed speech and right body weakness. Neurologic examination revealed motor aphasia and a right facio-brachio-crural sensorimotor hemisindrome. A left sylvian ischemic lesion was present on CT scan. Panel A of the figure shows right facial paralysis of the central type (i.e., with sparing of forehead musculature) as well as unexpected left ptosis and myosis (partial left Horner syndrome). The latter findings raised the suspicion of a left internal carotid artery (ICA) dissection with secondary injury to the ipsilateral perivascular sympathetic plexus. On contrast-enhanced MRI (figure, B), the left ICA was no longer detectable 2 cm after the common carotid bifurcation (full arrow), indicating reduced blood flow in this vessel. A transverse view (figure, C; dotted line in B) confirmed that the stroke was secondary to left ICA dissection by showing torn vessel wall (open arrowhead), crescent-shaped hematoma (open arrow), and reduced lumen (full arrow). The patient was anticoagulated and partially recovered over the following months.

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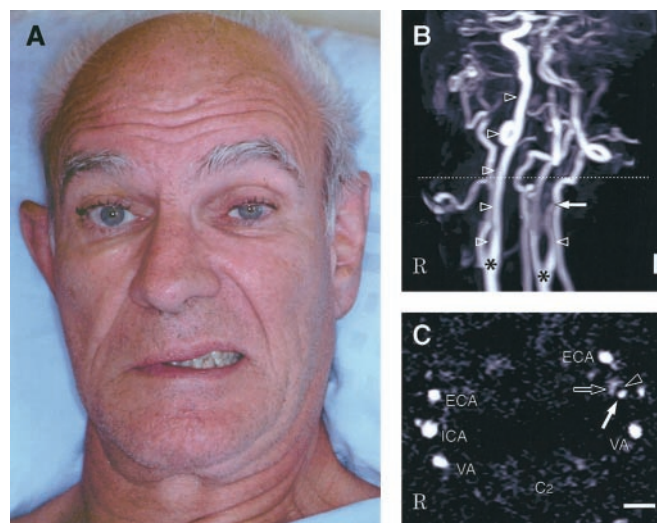


Figure. Asterisks indicate common carotid bifurcation; rightward open arrowheads, normal right internal carotid artery (ICA); leftward open arrowhead, proximal left ICA. ECA = external carotid artery; VA = vertebral artery; C₂ = body of C₂. Scale bars 1 cm.

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