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Letters to the Editor


Transient pure sensory strokes in patient with aneurysm of rostral basal artery

Pur sensory stroke (PSS) usually results from a lacunar infarct in the sensory nucleus of the thalamus,1 however, ischaemic and haemorrhagic lesions with various locations have also been reported.2,3 We studied a patient with PSS in whom an aneurysm of the rostral basal artery was disclosed by CT scan and MRI.

On the day of admission a 78 year old, right handed man developed three brief episodes of numbness and unpleasant dysesthesia on the right side of the body. He had no headache, stiff neck, dizziness, or visual symptoms. He was in good condition.

General physical examination was unremarkable and laboratory studies showed normal results. Electroencephalogram, somatosensory, brainstem auditory, and visual evoked potentials were also normal. The CT scan showed a round area of contrast enhanced density in the region of the interpeduncular fossa, with the CT features of a rostral basal ganglionic aneurysm (figure, top). MRI confirmed the presence of an aneurysm extending from the upper pons to the inferior aspect of the third ventricle without affecting the thalamus and compressing the left cerebral hemisphere slightly (figure, middle). MRI disclosed hyperintense images within the aneurysm, suggesting a clot inside its lumen (figure, bottom). Both CT scan and MRI did not show any abnormality of a focal nature in the brainstem, internal capsule, basal ganglia, or cerebral hemispheres. A digital venous angiogram showed no stenosis or ulceration in the carotid or basilar arteries. Reappearance of the pulsating aneurysm later showed a normal neurological examination, and the patient reported that no other similar disturbances had occurred.

The neurological disorder in this patient met the established criteria for transient ischaemic neurological deficit (TIA) as they resolved within a few minutes after onset. Both CT scan and MRI showed a saccular aneurysm of the rostral basal artery six months after any other pathological change elsewhere in the brain. Therefore the precise vascular territory affected cannot be identified, but on the basis of the aneurysmal location the reduced vascular supply of the thalamus or of the upper midbrain explains the symptoms and signs presented.4

Asymptomatic aneurysms

Figure. CT scan showing right basal ganglia haemorrhage

carotid angiogram did not show a vascular lesion.

Traumatic basal ganglia haemorrhage is a rare (3%) complication of severe closed head injury, occurring mainly in the young,1 the proposed underlying mechanism is shearing of an anterior choroidal or lenticonvolutar artery due to violent deceleration-deceleration brought about by a high velocity injury.2 In almost every case the haemorrhage is accompanied by the usual patho-logical features of severe head injury—for example, diffuse axonal injury, multiple contusions, and epidural or subdural haematoma.3 In one large series patients with a traumatic basal ganglia haemorrhoma had a poor prognosis4 but cases with a favourable outcome have been reported.5 Basal ganglia vascular lesions that do not involve the internal capsule may be asymptomat-ic,6 and subcortical vascular lesions of the dominant hemisphere may bring about only aphasic disturbances5 or even be clinically silent.7 Small basal ganglia haemorrhages in the non-dominant hemisphere may not be associated with the typical cognitive and behavioural disturbances (left neglect, visuospatial impairment etc).8 The interest of the present case lies in its favourable outcome. Although an early CT examination was not performed, we suggest that the early absence of neurological or EEG abnor-malities reflected a slow development of the haematoma.

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Traumatic basal ganglia haemorrhage with slight clinical signs and complete recovery.

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J Neurol Neurosurg Psychiatry 1992 55: 72
doi: 10.1136/jnnp.55.1.72

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