CSF hydrodynamics in superior sagittal sinus thrombosis

Bo Kristensen, Jan Malm, Peter Markgren, Jan Ekstedt

Abstract
Cerebrospinal fluid hydrodynamics were investigated with a constant pressure infusion method in patients with superior sagittal sinus thrombosis. Ten patients were studied with serial examinations up to 15 years after the onset of the disease. A total of 70 CSF hydrodynamic examinations were performed. A clear increase in intracranial pressure due to raised pressure in the major dural sinus was seen in all patients. A striking feature was the persistent intracranial pressure increase that declined only gradually. This had no obvious clinical impact. Change in CSF resorption facility played only a minor role in the intracranial pressure elevation. None of the patients developed hydrocephalus.

Aseptic cerebral venous thrombosis, mainly in the form of superior sagittal sinus thrombosis (SSST), is a fairly uncommon but important cause of raised intracranial pressure. Onset is often acute and dramatic. SSST is more common in younger adults and in women. There are many underlying causes but none is found in a quarter of cases. Most run a benign course in the acute phase. The mortality probably does not exceed 10%, and only about 20% of survivors are left with sequelae. Little is known about the long term outcome or risk of recurrence. Recently there has been interest in unusual aspects of presentation, causes, or treatment of SSST. Simple lumbar CSF pressure measurements have been reported from patients with sinus pathology but no serial investigations have been performed. CSF hydrodynamics have been studied by direct intrasinal and intraventricular pressure measurements in individual patients in special circumstances, such as during anaesthesia or neurosurgery, but fundamental pathophysiological changes in CSF hydrodynamics in SSST over time have not been reported. We present the first long term study on CSF hydrodynamics in patients with SSST.

CSF hydrodynamic investigation was performed according to the method described by Ekstedt. After 12 hours’ bed rest, two needles were inserted in the L3-L4 interspace. CSF (2 ml) was aspirated to check for free CSF passage from each needle. The patient was then examined lying supine with the zero pressure reference level at the cranial sagittal centre. Drainage of CSF and infusion of artificial CSF was made to and from a continuously weighed bottle. The pressure in the bottle was regulated by means of an electronic control system acting on the fluid in the bottle by means of the air pressure from a pump. CSF resting pressure (Prest) was determined when the resting recording had been stable for at least 10 min, which usually required 30–60 min recording. The conductance of the CSF outflow pathways (Gout) was determined by applying multiple pressure levels to the CSF space while recording the resulting inflow of artificial CSF into the patient. Thus within a few minutes a stable flow at a stable pressure was obtained. Usually, three different pressure/flow values were aimed at. The volume accounting method was used to calculate the pressure/flow relation. The slope for the pressure/flow values is equal to the CSF outflow conductance. The CSF formation rate (qf) was determined by lowering the CSF pressure to a value of about 0 kPa for a sufficient period to produce a stable pressure and outflow into the bottle. Finally, the pressure difference across the CSF outflow pathways (Pout) and the sagittal sinus...
pressure \( P_{\text{es}} \) were calculated according to the formula\(^\text{12} \):

\[
P_{\text{es}} = qfG_{\text{op}} \quad \text{and} \quad P_{\text{ss}} = P_{\text{ct}} - P_{\text{dop}}
\]

The calculated values of \( P_{\text{es}} \) express the mean value of the pressures in the major dural sinuses. The normal values for CSF hydrodynamic variables (table 1) were obtained from patients in whom medical history, as well as medical and neurological investigation, indicated no organic neurological or circulatory disorder. This control group included 58 patients\(^\text{13} \).

Unit j have been used, and the following conversion factors may be useful: pressure \( (1 \text{kPa} = 102 \text{ mm H}_2\text{O} = 7.5 \text{ mm Hg}) \); conductance \( (1 \text{ mm}^3 \text{kPa}^{-1} \text{sec}^{-1} = 6 \times 10^{-3} \text{ ml} \text{ (cm H}_2\text{O})^{-1} = 8 \times 10^{-3} \text{ (mm Hg)}^{-1} \text{ min}) \); and resistance (the inverse of conductance).

Results

The clinical findings are summarised in table 2. Six patients (patients 1, 3, 4, 5, 6, and 8) had a well defined syndrome with symptoms related to intracranial hypertension (headache, papilloedema, impaired consciousness), with or without generalised epileptic seizures. The others had focal symptoms, with or without signs of intracranial hypertension. Two patients were left with sequelae (table 3). Only one of the four patients who had generalised epileptic seizures in the acute phase had later recurrence (patient 7). The others have stopped anti-epileptic drugs.

Neuroradiology Selective carotid angiography identified seven patients with an isolated SSST (no involvement of other sinuses). The occluded sinus could not be visualised in five patients, indicating complete thrombotic occlusion (table 4). The three patients investigated at least one month after onset all had a partial, isolated thrombosis. Each patient's CSF hydrodynamic variables are shown in figure 1. All patients had raised sagittal sinus pressure \( P_{\text{es}} \) and intracranial pressure \( P_{\text{ss}} \) at their first investigation. The pressure difference across the CSF outflow pathways \( P_{\text{dop}} \) was preserved or slightly increased. Six patients were studied within two months after onset. The highest pressure was recorded at either the first or second measurement. Pressures gradually declined \( P_{\text{es}} \) and \( P_{\text{ss}} \) over time in all patients but returned to normal in only two patients (case 7 and 10) after eight and 15 years, respectively. The presence of total or partial thrombosis on initial angiography did not appear to correlate with the long term development of pressure or to clinical outcome. Conductance was normal or slightly to moderately decreased. A more pronounced

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Sex</th>
<th>Age at onset (years)</th>
<th>Follow up (months)</th>
<th>CSF hydrodynamic investigations (No)</th>
<th>Duration between onset and first investigation (months)</th>
<th>Mode of presentation</th>
<th>Neurological features</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>20</td>
<td>52</td>
<td>4</td>
<td>2</td>
<td>Acute</td>
<td>Sonnolens, Ha, Pe, GES</td>
<td>Hereditary AT III-deficiency</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>23</td>
<td>136</td>
<td>9</td>
<td>0:1</td>
<td>Subacute</td>
<td>Partial motor seizures, Hb, Ha, Pe</td>
<td>Colitis ulcerosa</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>22</td>
<td>70</td>
<td>9</td>
<td>1</td>
<td>Subacute</td>
<td>Ha, Pe</td>
<td>Idiopathic</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>36</td>
<td>64</td>
<td>6</td>
<td>9</td>
<td>Subacute</td>
<td>Ha, Pe</td>
<td>Idiopathic</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>53</td>
<td>184</td>
<td>12</td>
<td>24</td>
<td>Chronic</td>
<td>Ha, Pe, Pe</td>
<td>Head injury</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>23</td>
<td>25</td>
<td>2</td>
<td>5</td>
<td>Acute</td>
<td>Sonnolens, Ha, Pe, GES</td>
<td>Post partum</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>35</td>
<td>99</td>
<td>8</td>
<td>2</td>
<td>Acute</td>
<td>Pe, Pe, GES</td>
<td>Post partum, hereditary dysfibrogenemi</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>21</td>
<td>122</td>
<td>12</td>
<td>1</td>
<td>Subacute</td>
<td>Ha, Pe, Pe, GES</td>
<td>Oral contraceptives</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>18</td>
<td>60</td>
<td>6</td>
<td>2</td>
<td>Acute</td>
<td>Sonnolens, Ha, Pe, GES</td>
<td>Idiopathic</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>40</td>
<td>180</td>
<td>2</td>
<td>108</td>
<td>Chronic</td>
<td>Partial complex seizures, Hb</td>
<td>Sarcoideosis</td>
</tr>
</tbody>
</table>

GES = generalised epileptic seizures; Ha = headache; Pe = papilloedema; Hb = hemiparesis.
decrease was seen in patients with a complete sagittal sinus thrombotic occlusion. No consistent changes in conductance were seen although in some cases an initial decreased conductance was later normalised. The CSF formation rate (qf), which was normal in all patients, did not vary over time. No optic nerve damage could be detected except for slightly enlarged blind spots three patients (1, 2, and 4). Hydrocephalus was not found in any of the patients on repeated CT scans (table 5). When seen, signs of cerebral oedema resolved in all cases with time. No patient had a recurrence of thrombosis.

Neuropsychological assessment Four patients (3, 4, 7, and 8) were evaluated at least twice in the chronic stage with standardised neuropsychological testing; one patient had four examinations. No overt clinical symptoms related to cognitive dysfunction were found in these four. Patient 2 had a normal test result five years after onset. A slight decrease in fine motor speed in the right hand and in the ability for perceptual analysis was noted in patient 4, 18 months after the onset of symptoms. In patient 7 a discrete impairment was seen at the first investigation and a minor deterioration involving inductive logistics and learning of audioverbal information had occurred at final testing seven years later. In patient 8 a minor decline in tests of recent memory with subclinical dysfunction of higher adaptive ability was detected six years after baseline testing.

Table 4 Angiographic findings in 10 patients with superior sagittal sinus thrombosis

<table>
<thead>
<tr>
<th>Patient No</th>
<th>SSS</th>
<th>Other sinus involvement</th>
<th>Cerebral veins</th>
<th>Collaterals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Partial</td>
<td>Yes</td>
<td>No</td>
<td>Transcerebral</td>
</tr>
<tr>
<td>1</td>
<td>+</td>
<td>+</td>
<td>LS + SS</td>
<td>+</td>
</tr>
<tr>
<td>2</td>
<td>+</td>
<td>+</td>
<td>SS</td>
<td>+</td>
</tr>
<tr>
<td>3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>5</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>6</td>
<td>+</td>
<td>+</td>
<td>SS</td>
<td>+</td>
</tr>
<tr>
<td>7</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>8</td>
<td>+</td>
<td>+</td>
<td>LS</td>
<td>+</td>
</tr>
<tr>
<td>9</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>10</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

SSS = superior sagittal sinus; SS = straight sinus; LS = lateral sinus.

Discussion
The natural history of SSST has not been well documented. We have studied CSF hydrodynamics over a mean of 5-8 years from the acute or subacute to the chronic phase in 10 patients with SSST, and our patients may thus reflect the normal course of the condition. None of our patients underwent shunting or other neurosurgical procedures, and only two patients were optimally treated with anticoagulants (heparin in the acute phase) and some had short term medical treatment aimed at reducing brain oedema in the acute phase (including steroids, mannitol, or diuretics). The main limitation of this study was that the patients studied were highly selected. Most were suspected of having intracranial hypertension and were referred to our clinic, which offers the facilities for CSF hydrodynamic monitoring. Thus neither acute cases with a fulminating course nor the benign forms which recover rapidly and completely are likely to have been referred. The clinical characteristics of our patients do not, however, essentially differ from contemporary clinical materials.

There are three intracranial components or compartments—brain tissue, blood, and CSF—that if pathologically altered could cause intracranial hypertension. Our view of the predictable hydrodynamic consequences of a superior sagittal sinus thrombosis is illustrated in figure 2. In our patients, the main hydrodynamic features were increase of Pc and Pw. Animal studies have shown a direct relation between the increase in sagittal sinus pressure and CSF pressure,14 and CSF pressure will increase by an amount equal to the increase of Pw.15 When sagittal sinus pressure is raised, engorgement of cortical veins is likely to cause an increase in total intracranial blood volume consequent on the impaired venous flow into the sagittal sinus. This excess intracranial volume may further increase intracranial pressure. The increase of intercerebral venous blood pressure elevates hydrostatic capillary pressure, thereby producing an increase in net capillary filtration and the possibility of a progressive cerebral oedema. Ventricular compression may be seen on CT scan in up to half of patients in the acute phase of SSST.16 The increase in brain volume may in itself lead to an additional increase in Pw.17 Direct compression of the sinuses and lateral lacunae may follow
Figure 1. Course of various pressure values ($P_{up}$, $P_{op}$, $P_{cr}$) and conductance ($G_{cp}$) plotted against time. Dotted line in pressure value curves marks 90% confidence limit for $P_{cr}$ upper normal value. Low conductance values are defined as values falling within shaded area on $G_{cp}$ curves.
Sinus thrombosis

Different etiological factors

Primary thrombosis of a cerebral sinus

Impediment of the sinus blood outflow

Increase of Sagittal Sinus Blood Pressure (Pc)

Increase of CSF Pressure (Pc)

Increase of intracerebral venous blood pressure (Pcv) and volume (brain oedema)

Impediment of Cerebral Function

Direct compression of sinuses by brain tissue

With time

Establishment of collateral venous circulation

Resolution of brain oedema, lessened sinus compression and reduction of Pc

Normalisation of cerebral function

Chronic stage with persistently elevated Pc

In a few patients:

Local impediment of villus function in sinus and lateral lacunae

A slight decrease of Conductance (Gop)

Preserved or slightly increased CSF-sagittal sinus pressure gradient

Figure 2 Overview of mechanisms and development of CSF hydrodynamic events after SSST, according to findings in present study.

elimination of the parasagittal subarachnoid space, further compromising venous outflow.

If further pressure elevation occurs or is not relieved, coma and death may ensue. In most patients, however, the deterioration is transient and spontaneous improvement is the rule. This improvement is probably more a reflection of the adequacy of collateral channels than to restoration of blood flow through a recanalised occluded sinus lumen. In case 9 a first angiogram three days after onset of symptoms showed a complete thrombosis but no collaterals, and he was in a critical phase for 10 days. Two weeks later a second angiogram clearly showed collaterals but the thrombotic occlusion was completely unchanged. The persistently high Pc in our patients may well indicate that thrombotic occlusion is commonly permanent. It should be emphasised that Pc represents an indirect calculated mean pressure of the major dural sinuses and is presumably raised in the case of obstructed venous outflow due to thrombosis of the superior sagittal sinus or its bridging veins, or both. In patients who survived for a considerable period after SSST but were examined postmortem the lumen of the superior sagittal sinus has been reported to be almost completely occluded by fibrous tissue with only small sinusoidal channels present which would not have permitted adequate drainage of venous blood from the brain. In individual patients the amount of blood flowing out through collaterals or a partially patent sinus probably varies. Collaterals were present in all our patients who had a complete thrombosis. Those patients with no collaterals on angiography would have to rely on sufficient outflow via the sinus (patient 3). Bousser et al reported that all patients with complete SSST in a group with cerebral vein thrombosis had anastomoses on angiography whereas two patients with partial thrombosis did not. In our series one patient (patient 10) whose pressure levels returned to normal had a repeat angiogram five years after onset which showed a more extensive collateral system that might explain the decrease in pressure levels.

Treatment in the acute phase should aim to induce thrombolysis and prevent further thrombosis. Effective thrombolysis in the early stage might prevent the persistent intracranial pressure elevation that we saw in our patients. Several studies have reported the use of fibrinolytic treatment with varying success. Early heparin treatment may improve outcome
by preventing thrombus extension\textsuperscript{29} which further compromises the outflow of venous blood, additionally increasing intracranial pressure. Total sagittal sinus occlusion is said to be often fatal.\textsuperscript{31} In our study, no obvious difference in the clinical course and hydrodynamic variables was detected between cases with partial and complete thrombosis, probably reflecting the limited size and selectivity of our material.

An occlusion of the superior sagittal sinus may, to some degree, obstruct resorption of CSF by the arachnoid villi (a lower conductance), leading to increased CSF pressure. In our patients, conductance was normal or only slightly to moderately decreased (moderate reduction occurring in patients with a complete thrombosis). Conductance, when failing to improve during follow up, may be a consequence of a permanent disturbance of arachnoid villus function. As the CSF formation rate did not vary P\textsubscript{dop} will be preserved or increased when conductance is lowered according to the classic relation P\textsubscript{dop} = qfr/G\textsubscript{dp}. The maintenance of the cerebrospinal-sagittal sinus gradient encourages CSF resorption. Alternative CSF pathways through venous collateral vessels may also play a part in CSF drainage. Therefore, a fairly small disturbance occurs in the CSF absorption process with only a minor contribution to intracranial pressure elevation. Under these circumstances treatment by serial lumbar punctures or various shunting procedures can hardly produce more than a marginal pressure lowering effect.

Only a few studies have described the hydrodynamic effects of sagittal sinus obstruction. One of these reported a reversed or nullified P\textsubscript{dop} but conductance was normal or slightly reduced.\textsuperscript{1} Simultaneous recording of sagittal sinus pressure and intracranial pressure in humans and experimental animals, however, has shown that a positive CSF-sagittal sinus pressure gradient is almost always maintained despite gross elevations in both the intracranial and sinus pressures.\textsuperscript{13 22 23}

In animal studies a chronically increased intracranial venous pressure has produced a communicating hydrocephalus.\textsuperscript{32} Others, however, have failed to produce hydrocephalus after experimental venous outflow obstruction.\textsuperscript{25 26} Clinically, ventricular enlargement rarely occurs in SSST.\textsuperscript{27} Serial enlargement of the ventricles over the course of one to two weeks has been shown as cerebral oedema resolved.\textsuperscript{28} In another study, six patients with sagittal sinus pathology underwent CT scanning once, a few days to a year after onset. No ventricular enlargement was found.\textsuperscript{31} In our patients CT scans were performed over a much longer time span; no patient developed communicating hydrocephalus, which supports the results of their hydrodynamic profile. In some cases CSF outflow conductance was only moderately decreased compared to other conditions characterised by hydrocephalus.\textsuperscript{29 30} Furthermore, the preservation of the pressure gradient between the subarachnoid space and the venous side of the dural sinuses might be the main factor preventing hydrocephalus. A transcerebral pressure difference between the ventricular system and the subarachnoid cortical space as a cause of ventricular enlargement should not be present in those patients in whom the freely patent CSF spaces prevent the development of any such pressure gradients.

In the event of acute intracranial pressure elevation, alterations in consciousness disappear as cerebral oedema resolves. Survivors generally recover completely. Hydrodynamic abnormalities may still be seen many years after SSST but when oedema has resolved a high intracranial pressure does not seem to substantially impair cerebral function. Neurophysiological testing, however, showed some patients to have discrete signs of cognitive dysfunction. No serious visual complications were found in our patients despite their persistently elevated intracranial pressure. The limited ability to compensate for a possible additional increase in intracranial pressure may mean that patients with SSST who develop a stroke or who receive a head injury have a higher risk.

Our results show that after superior sagittal sinus thrombosis, hydrodynamic abnormalities, particularly persistently raised CSF pressure mainly due to raised P\textsubscript{dop} remain for many years. The change in conductance or CSF resorption facility plays only a minor part in the increase in intracranial pressure. Despite the persistently raised CSF pressure hydrocephalus does not develop and the long term clinical course is generally benign.

We thank Björn Hägglöf for his helpfull comments concerning the neurophysiological aspects of this article. Financial support from Karl-Oskar Hansson’s foundation, The Swedish Society for the Neurologically Disabled (NHR), and Norrlandsfonden is gratefully acknowledged.

\textsuperscript{5} Caumulf GM, Haines LA. Increased intracranial pressure following compression of the superior sagittal sinus. Neurology (Minneapolis) 1953;3:251–253.
\textsuperscript{14} Guthrie TC, Dunbar HS, Kapell B. Ventricular size and chronic increased intracranial venous pressure in the dog. J Neurol 1970;33:407–14.