headache increased in severity and developed over the
contraceptive pills for the last six years and she was
advised to stop them. Over the next days, the bruit and
family history were not contributory. She had been on
trauma to the head or neck and her past medical and
pressure: 190/120 mmHg. There was no history of
a normal neurological examination, but a high blood
tension of headache, neck pain, vomiting and of a bruit in the
Clinique des Maladies du Systeme Nerveux, Hopital de la Salpetriere
years ago, but has recently become either less unusual
artery (VA) was considered to be a rare entity a few
UNILATERAL SPONTANEOUS DISSECTION of
the internal carotid and/or vertebral arteries re-
We report two patients with
spontaneous acute dissection of at least three major
cervical arteries.

**Report of Cases**

**Patient 1**

A 40 year old woman was admitted to La Salpetriere
on February 5, 1982, two weeks after the acute onset
of headache, neck pain, vomiting and of a bruit in the
left ear. She was seen by her local physician who found
a normal neurological examination, but a high blood
pressure: 190/120 mmHg. There was no history of
trauma to the head or neck and her past medical and
family history were not contributory. She had been on
contraceptive pills for the last six years and she was
advised to stop them. Over the next days, the bruit and
headache increased in severity and developed over the
whole of the head. Ten days after the onset of symp-
toms, she had a brief loss of consciousness and four
days later she had a sudden episode of bilateral blur-
ing of vision, which lasted 15 minutes. Clinical ex-
amination was normal except for the presence of a left
Horner’s syndrome and a loud bruit over the left side of
the head and neck. Blood pressure was 135/95 mmHg.
On admission the next day, clinical findings were
similar. Routine laboratory investigations and detailed
cogulation studies were normal. A CT scan with and
without contrast injection was normal. A percutaneous
transfemoral selective bilateral carotid and subclavian
angiography showed abnormalities on all 4 vessels. On
the right ICA (fig. 1-A), there was a severe extensive
narrowing beginning just past the origin and extending
up to the siphon which was filled retrogradely by the
external carotid artery via the ophthalmic artery. On
the left ICA (fig. 1-B), there were slight irregularities
at the origin, and distal to it, a severe narrowing ex-
tending up to the entrance into the carotid canal, with
an aneurysmal dilatation at the C3 level. On the left VA
(fig. 1-C), there was, distal to its origin, a moderate
irregular narrowing extending up to the C3 level with
two aneurysmal dilatations, one at the C3-C2 level and
the other on its extracranial curve. The right VA (fig.
1-D) was hypoplastic and, in addition, showed a severe
regular excentric stenosis at the C3 level. The left VA
filled both middle cerebral arteries. The intracranial
circulation was otherwise normal. The abdominal aor-
ta and renal arteries were normal. High dose Heparin
calcium was started on Feb. 11. Over a period of two
weeks, there was a steady improvement with a gradual

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**Spontaneous Dissecting Aneurysms Of The Internal Carotid And Vertebral Arteries — Two Case Reports**

**JEAN-LOUIS MAS, M.D.* CATHERINE GOEAU, M.D.,* MARIE-GERMAINE BOUSSER, M.D.,**

**JACQUES CHIRAS, M.D.,† JEAN-MICHEL VERRET, M.D.,† PIERRE-JEAN TOUBOUL, M.D.**

**SUMMARY** Two patients had acute spontaneous dissection of both internal carotid arteries and of one or
both vertebral arteries. One had angiographic signs suggestive of fibro-muscular dysplasia and both were
on oral contraceptives. They were treated with high dose heparin and made a good clinical recovery. A
digital intravenous angiography performed two to three months later showed a complete recanalization of
arteries involved.

These patients are similar to those reported as “idiopathic regressing arteriopathy” and “reversible
angiopathy” which probably correspond to the same entity.

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Received November 30, 1982; revision #2 accepted July 23, 1984.
disappearance of the bruit and headache. She was dis-
charged on oral anticoagulants and was examined
monthly afterwards. She had no further symptoms;
blood pressure was always normal and the only anom-
aly is a left Horner’s syndrome. A digital intravenous
angiography (DIVA) was performed 3 months later
(fig. 1-E); it showed a complete recanalization of the
right ICA, right VA and left ICA, and the persistance
of a sacciform aneurysm of the left ICA at C1 level.
The left VA was not properly visualised but continuous
wave Doppler showed normal velocity curves of both
VA suggesting the absence of hemodynamically sig-
ificant stenosis.

Patient 2

On February 20, 1982, a previously healthy 42 year
old right handed woman experienced a 10 minute epi-
sode of bilateral blurring of vision. A similar episode
occurred the next day and was accompanied by a severe
neck pain which worsened during the following hours
and lasted a week. On Feb. 28, she suddenly heard a
pulsatile bruit in the right ear and developed weakness,
numbness and tingling in the left leg, extending in a
few hours over the whole left side of her body. The
weakness worsened over the next three days, and then
gradually improved. Fifteen days after the onset of
symptoms, she was seen by one of us (J.M.V.) and
admitted to her local hospital. Clinical examination
was normal except for a slight impairment of joint
position sense on the left side. A transfemoral aorto-
graphy and cerebral angiography was performed on
March 11: it showed a severe, irregular narrowing of
the right ICA extending from the C2 level up to the
entrance into the carotid canal with an aneurysm at C1
level (fig. 2-A). The left ICA was not selectively
visualised but continuous wave Doppler showed normal
velocity curves of both VA and left ICA with persistance
of an aneurysmal dilatation at C1 level (fig. 2-B). The
intracranial circulation was otherwise normal. The ex-
traenal portion of the right renal artery showed a nar-
wowing with a “string of beads” appearance. On the
day after angiography, she suddenly developed a
speech impairment. High dose heparin sodium was
immediately started and she was transferred to our
hospital.

On admission (March 12), she had a moderate dys-
phasia involving speech, reading and writing func-
tions. Neurological examination was otherwise nor-
mal. There was no cervical or cranial bruit. Blood
pressure was 140/80 mmHg. There was no past history
of head or neck traumatisms, even minor ones, have been specifically
looked for and denied by the patient.

Clinical manifestations and angiographic signs of
spontaneous dissections of cervical arteries need not to
be detailed since they are well documented.1 2 Clinical
manifestations usually associate "local" signs such as
headache, bruits and Horner’s syndrome4 to signs of
cerebral ischemia referring to the territory of the artery
involved. These signs can be transient or permanent,
such as in our patient 2, who had first two vertebobas-
ilar TIA’s, then one right carotid reversible deficit and,
after angiography, a left carotid completed stroke with
permanent dysphasia. The diagnosis of dissection lies
upon angiography. In both patients, signs of dissection
were typical on at least one V.A. and on the two I.C.A.
with long irregular filling defects ("the string sign"),1
thus eliminating other entities such as spasm, athe-
rosclerosis and arteritis. The almost total disappearance
of these anomalies in a few months is also very sugges-
tive of dissection.3 13 14 Follow up angiography is
therefore crucial in these patients. DIVA seems to this
respect an excellent non invasive and easily repeatable
investigation. It showed in the present patients a com-
plete recanalization of carotid and vertebral arteries.

The spontaneous occurrence of a dissection is al-
ways difficult to assess with certainty. A variety of
circumstances associated with abrupt change in head
position, such as chiropractic manipulation,15 gymnas-
tic exercises or sports activity or even “head bang-
ing,”16 can lead to hyperextension or rotational injury
to the neck and induce the formation of an arterial
dissection. In the mind of the patient, these events are
considered to be non traumatic and therefore are not
spontaneously reported. In our cases, all these possible
traumatisms, even minor ones, have been specifically
looked for and denied by the patient.

Spontaneous multiple dissection of the major cervi-
cal arteries is very unusual. Among the reported cases,
diagnosis rested either on pathological examination6 9
or on angiographic changes.3 4

Our two cases are clinically and angiographically

Discussion

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![Figure 1. Patient IA — Right ICA: right stenosis with pseudo-occlusion extending from 1 cm above the origin up to the siphon (•), B — Left ICA: severe, irregular stenosis at C2-C1 level (•) with aneurysmal dilatation (→) just below the entrance into the carotid canal. C — Left VA: Irregular stenosis from C6 to C3 with aneurysmal dilatation at C3-C2 level (•) and saccular aneurysm at C1 level (→). D — Right VA: severe eccentric narrowing at C1 level (•). E — DIVA (3 months later): recanalization of the right ICA (→); right VA (•) and left ICA with persistance of an aneurysmal dilatation at C1 level (→).](http://stroke.ahajournals.org/doi/abs/10.1161/01.STR.16.1.126?journalCode=stra)
similar to those reported as "idiopathic regressing arteriopathy,"10 "spontaneous bilateral recanalization in bilateral carotid artery occlusion,"11 or "reversible angiopathy."12 It is highly probable that all these eponyms correspond to acute multiple spontaneous dissections of cervical arteries. The presence of multiple arterial involvement suggests the presence of an underlying arterial disease that could lead to weakness of the vessel wall and formation of an arterial dissection. In patient 2, the "string of beads" appearance of the right renal artery was that described in fibromuscular dysplasia (FMD). It is therefore possible that FMD was also present in cervical arteries. The association between spontaneous dissection and FMD is well documented.1-5, 8, 9, 14-18 It has been suggested that minor injuries to the neck could be sufficient to cause dissections of arteries involved by FMD,9 and that elevated blood pressure due to renal FMD could be a contributing factor.8 Migraine has been suggested as another etiologic factor20,21 but our patients denied any history of migraine. Oral contraceptives which are known to induce intimal hyperplasia22 and other changes in the arterial wall have also been incriminated2-10,11 and it is of interest that our two patients were on oral contraceptives when the first symptoms occurred. Whatever the underlying disease, it should be stressed that: the relationship between these diseases and spontaneous dissections on one hand, and the mechanism by which all four arteries are simultaneously affected on the other, remain totally unclear.

The efficacy of any treatment in a disease which is often spontaneously reversible is extremely difficult to establish. Surgical treatment has been advocated, particularly in case of progressive or repetitive neurological deficits.1-4 Anticoagulants3, 23, 24 or antiplatelet drugs3, 18 have been widely used in order to prevent thrombosis of the lumen or embolization of a mural thrombus. High dose heparin was used in the two present patients because of these observations and also based on our personal experience of non surgical treatment.19 In a series of 24 patients with spontaneous ICA dissection followed up by angiographic (18 cases) or ultrasound studies (6 cases), recanalization was observed in 16. Of these, 10 were treated by anticoagulants, 5 by aspirin and one had no treatment. By contrast, among the 8 patients who had no recanalization,
only 2 were on anticoagulants, 2 on aspirin and 4 had no treatment. Although this was not a randomized study, it suggests a slightly better prognosis in patients treated by anticoagulants or aspirin than in patients with no treatment.

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