Atypical Progressive Stroke Syndrome Associated With Oral Contraceptives and Cigarette Use

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We report a case of progressive multifocal intracranial distal arterial branch occlusive disease in a young adult who smoked heavily and used oral contraceptives. The distribution of the angiographic lesions and the associated telangiectasias and rete mirabile resemble Moya-Moya disease except for clearly absent proximal carotid arterial disease. This type of distal multifocal cerebral arterial occlusive pattern appears to be a very rare manifestation of cigarette and oral contraceptive use. The patient has remained without symptoms for > 3 years off oral contraceptives and cigarettes and on antiplatelet agents. (Stroke 1987;18:519–523)

Cigarette smoking1 and use of oral contraceptives (OC)2–3 are well known risk factors for ischemic stroke from cerebral arterial occlusive disease. In fact, they may even potentiate each other as stroke risk factors in a more than additive manner.4–3 Virtually all ischemic strokes associated with OC use result from large vessel (internal carotid, proximal middle cerebral, or vertebral artery) occlusion or high-grade stenosis.2–5 These have been documented angiographically6 and pathologically.7 Okawara and Calkins6 in 1973 reported 2 young women with ischemic strokes associated with OC use and angiograms resembling classic Moya-Moya disease, including the significant proximal cerebral arterial occlusions. We now report a case of progressive multifocal intracranial distal arterial branch occlusions without proximal carotid arterial disease in a young woman who used OC and also smoked heavily.

Report of a Case

A 20-year-old right-handed white woman was well until September 1980 when at age 18 she had an episode of right hand numbness followed in 24 hours by left hand numbness, both lasting 3 months and gradually resolving without associated headache. In 1981, she noticed a right lower facial droop with right-sided weakness and numbness, which gradually resolved except for mild right lower facial and right hand numbness, again without headache. In June 1980 she had begun oral birth control pills. She had a generalized seizure 2–3 weeks later. In July 1982 she awoke with a left-sided throbbing headache with nausea. Two to three days later she noticed that the right side of her visual field was dark. Two days later she could not read. She could see and write words but could not understand the words. From July through September 1982 her visual and reading deficits improved mildly. On September 7, 1982, she was admitted to the University of Michigan Medical Center (UMMC) for the first time with complaints of inability to read, decreased vision, and right-handed numbness.

Past medical history was remarkable for questionable transient hypertension of uncertain validity on a previous admission to another hospital and a tonsillectomy. There was no history of migraine and no family history of migraine or similar stroke syndrome. Social history revealed that she smoked 2–3 packs of cigarettes a day for more than 6 years. There was no history of recreational drug or alcohol use. The only medication on admission to UMMC was phenobarbital 60 mg q.h.s. She had stopped oral contraceptives in August 1982.

On admission, her blood pressure was 135/85; pulse was 80 and regular. There were no carotid bruits, heart murmurs, or clicks. There was no rash, lymphadenopathy, edema, clubbing, splenomegaly, or peripheral cyanosis. All peripheral and cervicocranial pulses were normal.

Neurologic examination revealed the patient to be alert, slow but accurate to orientation, with marked acalculia and dyslexia without dysgraphia. There was a mild short-term memory loss and a moderate anoma. Testing of similarities, abstraction of proverbs, right–left orientation, repetition, and speech were slow but
intact. Neuropsychological testing revealed a mild constructional dyspraxia and severely deficient short and long-term visual retention. She had numerous difficulties with cognitive tasks, especially with delayed recall of verbal and visual stimuli. Her cranial nerve examination was remarkable for a subtle right homonymous hemianopia, upper motor neuron weakness of the right face, and poor initiation of saccades. Motor exam revealed subtle increased tone and dysdiadochokinesis in the right upper extremity. Her reflexes and power were normal. Sensory exam showed mild decreased graphesthesia on the right hand.

Serum chemistries, complete blood count and differential, platelet count and morphology, coagulation studies, urinalysis, serum protein electrophoresis, triglycerides, cholesterol, lipoprotein electrophoresis, fibrinogen, VDRL, ANA, complement factors, rheumatoid factor, blood culture, serum viscosity, and sedimentation rates were normal. Chest x-ray and ECG were normal. Skin tests for tuberculosis were negative. Two-dimensional and M-mode echocardiography and visual and brainstem evoked responses were normal. A phenobarbital level was 15 μg/ml. Head computed tomography scan revealed a small contrast-enhancing lucency in the left temporo-occipital region. There was a suggestion of small lucencies in the posterior portion of the left thalamus and posterior limb of the left internal capsule.

Four-vessel cerebral angiography revealed multiple occlusions of the secondary frontoparietal branches of the left middle cerebral artery (MCA) (Figure 1). Several frontal secondary and tertiary branches of the left MCA and anterior cerebral artery were occluded. Lush transthalamic and transpial collateralizations (telangiectasia and rete mirabile) were seen. Multiple tertiary branches of the right MCA and anterior cerebral artery also showed similar occlusions with transpial collateralization. Larger arteries at the base of the brain, the arch, and the neck were spared. Leptomeningeal biopsy was considered; however, the patient declined.

Platelet function during admission revealed increased aggregation of platelets spontaneously using the optical density technique with adenosine diphosphate as the stimulus (Bom’s method)\(^9\).

The patient was placed on aspirin, 325 mg/day, and dipyriramole, 25 mg t.i.d. and maintained on phenobarbital, 60 mg q.h.s. She stopped smoking. She has remained without symptoms, including seizures, for >3 years and has gradually improved in all areas of her neurologic deficits. Repeat platelet aggregation studies on therapy showed hypoaggregability of her spontaneous and induced aggregation parameters.

Discussion

To our knowledge, this is the first reported case of an atypical Moya-Moya pattern of multifocal, solely intracranial, distal branch arterial occlusive disease with telangiectasias associated with cigarette and OC use. In the vast majority of Moya-Moya cases, the supraclinoid internal carotid artery and major branches of the MCA show prominent occlusion, providing evidence of hyperaggregable platelets, specific etiology, or pathologic processes.\(^10\) Atypical Moya-Moya disease has been seen previously in infectious disease\(^9\) and arteriosclerotic disease.

Some authors\(^13\) believe this angiographic pattern results from slow arterial occlusions of the circle of Willis with subsequent proliferation of collateral arteries. Hilal and coworkers\(^18\) demonstrated telangiectasia of vessels in the basal ganglia functioning as transcerebral collaterals to the leptomeningeal branches of the MCA. They felt that this hypervascularity was favored by the young ages of the patients and the gradual nature of the arterial stenosis. Our patient’s pattern of secondary and tertiary branch occlusion of the left MCA with total sparing of the carotid, circle of Willis, and proximal MCA vessels is highly atypical and quite uncharacteristic of the classic descriptions of Moya-Moya disease. The collateralization and rete mirabile “puff of smoke” pattern distally are very characteristic of Moya-Moya, although telangiectasia is not diagnostic. Our case, then, suggests that occlusive carotid arterial disease proximal to the circle of Willis is not necessary for the appearance of rete mirabile.

Okawara and Calkins\(^6\) described 2 young women with ischemic stroke associated with OC use and angiography resembling classic Moya-Moya disease including proximal large vessel disease. One had abnormal platelet studies, hyperfibrinogenemia, and hypertriglyceridemia attributed to the OC. No note was made of smoking history.

Migraine accompaniments or equivalent as the only explanation for our patient’s strokes is probably untenable. There was no case history or family history of migraine. She had associated seizures, and this angiographic pattern has not been reported with migrainous infarction. There was no laboratory or angiographic evidence for vasculitis. Further, she had a relatively benign clinical course, absence of confusion and prominent headache, and an asymptomatic follow-up period of >3 years without specific antivasculitis therapy. The mildly elevated CSF IgG may be seen as a response to a heterogeneous group of CNS insults, including cerebral ischemia. There was also no systemic, auscultative, ECG, or echocardiographic evidence of a cardiac embolic source. Accelerated atherosclerotic cerebrovascular disease was not supported by laboratory or angiographic data.

Kalendovsky and coworkers\(^2\) described 4 young patients with cerebrovascular occlusions and increased...
FIGURE 1. Lateral (A) and frontal (B) views of left common carotid arteriogram show multiple tangles of tiny collateral vessels (bold arrows) resulting from branch occlusions. Anterior cerebral artery is occluded and reconstituted at point marked by crossed arrow. A generalized paucity of peripheral branch filling is most noticeable in the anterior parietal territory (star in A). Internal carotid artery and proximal main trunks of the anterior cerebral and middle cerebral arteries are not involved (arrowheads in B). Proximally stenosed left posterior cerebral artery (open arrows in A) is reconstituted by the anterior choroidal artery and was the only involved portion near the circle of Willis, all other disease being more peripheral.
platelet aggregability. Three patients had a history of OC use; 3 also had associated vascular headaches for some years prior to their first occlusive event. Angiograms were described as showing proximal internal carotid or MCA occlusions or luxury perfusion without abnormal blood vessels. Al-Mefty and coworkers reported 22 cases of transient ischemic attacks with increased platelet aggregation and adhesiveness, excluding those with other complicating pathology (including OC use). In 2 cases, aged 12 and 18 years, angiography revealed multiple occlusions of small branches of the MCA.

Preliminary data suggest that even 2 cigarettes smoked in succession can increase platelet stickiness, though these authors were measuring adhesiveness, not aggregability. Subsequent results have been conflicting concerning smoking and increased platelet aggregation. Small studies of immediate effects suggest an increased platelet activation with smoking, while data from other investigators increase, including the most recent and extensive prospective study to date. Our patient had a 2-3-pack-a-day cigarette history for several years prior to her initial presentation. Smoking is an independent risk factor for stroke, although it is unclear that this is necessarily responsible for her hyperaggregability.

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References

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References

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