Multi-Detector Row Computed Tomography Angiography in Diagnosing Spinal Dural Arteriovenous Fistula

Initial Experience

Ping-Hong Lai, MD; Huay-Ben Pan, MD; Chien-Fang Yang, MD; Lee-Ren Yeh, MD; Shu-Shong Hsu, MD; Kwo-Wei Lee, MD; Mei-Jui Weng, MD; Ming-Ting Wu, MD; Huei-Lung Liang, MD; Clement-Kuen Chen, MD

Background and Purpose—Multi-detector computed tomographic (MDCT) angiography is a recently developed imaging technique that can study small vessels such as medullary arteries and veins. The purpose of this study was to evaluate MDCT angiography in diagnosing SDAVF.

Methods—Eight patients with initial magnetic resonance imaging (MRI) and clinical findings suggestive of spinal dural arteriovenous fistula (SDAVF) and 8 control subjects underwent MDCT angiography. Both MDCT angiography and catheter angiography were performed within 5 days in patients with SDAVF. The results of MDCT angiography in patients with SDAVF were compared with those of catheter angiography.

Results—MDCT angiography detected engorged perimedullary draining veins and correctly localized the fistula of the SDAVF, and correlated well with catheter angiography. Fistula was at the thoracic level in 7 patients, and sacral level in 1 patient. MDCT angiography did not visualize the engorged perimedullary venous plexus in the control group.

Conclusion—MDCT angiography correlated well with catheter angiography in diagnosing SDAVFs. It might play a role in shortening the length of the catheter angiography in diagnosing this disease. (Stroke. 2005;36:1562-1564.)

Key Words: angiography ■ arteriovenous fistula ■ central nervous system ■ computed tomography ■ spinal cord ■ vascular malformations
catheter angiographic examinations were performed with a previously described standard protocol. All angiographers were informed of the CTA results and were encouraged to select the specified arteries early in the procedure.

**Results**

All 8 patients had a SDAVF, and this CTA technique precisely identified the site of the fistula by recognizing the enlarged radiculo-medullary vein that drains the fistula. MDCT angiography is good at detecting the fistula, feeding artery, and engorged perimedullary veins of the SDAVFs, and correlated well with catheter angiography (Figures 1 and 2). Fistula was at the thoracic level in 7 patients and at the sacral level in 1 patient. The coexistent nonenlarged intercostal or internal iliac artery at the level of the fistula was observed as a major feeding artery to each fistula. An additional feeding artery was present in 1 patient with catheter angiography and was not prospectively identified with MDCT angiography. MDCT angiography did not visualize the engorged perimedullary veins in the control subjects. The $\kappa$ values for interobserver agreement of the MDCT angiography for detection of engorged perimedullary veins and localization of the fistula of the SDAVFs were 1.000 and 0.849, respectively.

**Discussion**

MDCT angiography provides very short scan time, more scan length coverage ($\approx 55$ cm), and higher spatial resolution ($0.5 \times 0.5 \times 0.75$ mm) compared with contrast-enhanced magnetic resonance angiography (MRA) ($36$ cm, $1.0 \times 1.0 \times 1.2$ mm) in diagnosing SDAVFs. Farb et al reported that repeated double/triple MRA was required to search the SDAVF in another region in more than half of the patients. In contrast, with the MDCT method, the added imaging volume was easily performed in the craniocaudal direction with an additional several seconds of examination. Another advantage of CTA is it allows observation of enhanced vessels among the bony structures. MDCT angiography is feasible and is an alternative modality in diagnosing SDAVF compared with contrast-enhanced MRA.

The search for a SDAVF at catheter angiography is often tedious and requires selective injections into multiple bilateral thoracic intercostal, lumbar, and sacral arteries. If no fistula is found, then cervical and intracranial regions are sequentially explored. An exhaustive search for a SDAVF may include as many as 40 selective injections. The ability to predict the fistula level noninvasively by MDCT angiography can potentially expedite subsequent invasive catheter angiographic examination by directing the angiographer to certain spinal levels initially. The commonly lengthy catheter
angiography sessions could be shortened by more than half of the time.

The disadvantage of MDCT angiography is the use of ionizing radiation. We opted to evaluate the field of view from thoracic spine to sacrum to include >90% of SDAVs, not including the intracranial and cervical spine regions, for minimizing radiation dose delivered to the patients. We assessed effective dose calculations by application of the CT dosimetry spreadsheet of the British Imaging Performance Assessment of CT (ImPACT) group. The average effective dose for MDCT angiography of the SDAVs was 9.1 mSv.

As is the case with MRA, the time resolution of CTA is not sufficient to distinguish anterior spinal arteries from draining veins in SDAV compared with catheter angiography. Catheter angiography is still mandatory before embolization to determine whether an anterior spinal artery arises from the same pedicle that supplies the fistula. If the same radicular artery supplies the SDAVF and anterior spinal artery, it may indicate a contraindication for endovascular treatment. Finally, case numbers limit the high reliability of MDCT angiography and interobserver agreement in diagnosing the SDAVF, and a large series of patients are needed to test in the future.

In conclusion, findings in this initial assessment have shown that MDCT angiography is good at detecting the fistula, feeding artery, and draining veins of the SDAVF, and correlated well with catheter angiography. This technique might greatly reduce the amount of time required for catheter angiography.

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References

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