Original Contribution

Differences and Similarities Between Spontaneous Dissections of the Internal Carotid Artery and the Vertebral Artery (Revision 2)

Michelle von Babo, MD*; Gian Marco De Marchis, MD*; Hakan Sarikaya, MD; Christian Stapf, MD; Frédérique Buffon, MD; Urs Fischer, MD; Mirjam R. Heldner, MD; Jan Gralla, MD; Simon Jung, MD; Barbara Goeggel Simonetti, MD; Heinrich P. Mattle, MD; Ralf W. Baumgartner, MD; Marie-Germaine Bousser, MD; Marcel Arnold, MD

Background and Purpose—To compare potential risk factors, clinical symptoms, diagnostic delay, and 3-month outcome between spontaneous internal carotid artery dissection (sICAD) and spontaneous vertebral artery dissection (sVAD).

Methods—We compared patients with sICAD (n=668) and sVAD (n=302) treated in 3 university hospitals.

Results—Patients with sICAD were older (46.3±9.6 versus 42.0±10.2 years; \(P<0.001\)), more often men (62.7% versus 53.0%; \(P=0.004\)), and presented more frequently with tinnitus (10.9% versus 3.4%; \(P<0.001\)) and more severe ischemic strokes (median National Institutes of Health Stroke Scale, 10±7.1 versus 5±5.9; \(P<0.001\)). Patients with sVAD had more often bilateral dissections (15.2% versus 7.6%; \(P<0.001\)) and were more often smokers (36.0% versus 28.7%; \(P=0.007\)). Thunderclap headache (9.2% versus 3.6%; \(P=0.001\)) and neck pain were more common (65.8% versus 33.5%; \(P<0.001\)) in sVAD. Subarachnoid hemorrhage (6.0% versus 0.6%; \(P<0.001\)) and ischemic stroke (69.5% versus 52.2%; \(P<0.001\)) were more frequent in sVAD. After multivariate analysis, sex difference lost its significance (\(P=0.21\)), and all other variables remained significant. Time to diagnosis was similar in sICAD and sVAD and improved between 2001 and 2012 compared with the previous 10-year period (8.0±10.5 days versus 10.7±13.2 days; \(P=0.004\)). In sVAD, favorable outcome 3 months after ischemic stroke (modified Rankin Scale, 0–2; 88.8% versus 58.4%; \(P<0.001\)), recurrent transient ischemic attack (4.8% versus 1.1%; \(P=0.001\)), and recurrent ischemic stroke (2.8% versus 0.7%; \(P=0.02\)) within 3 months were more frequent.

Conclusions—sICAD and sVAD patients differ in many aspects. Future studies should perform separate analyses of these 2 entities. (Stroke. 2013;44:00-00.)

Key Words: dissection ■ outcome ■ risk factor ■ stroke

Spontaneous cervical artery dissection (sCAD) is a major cause of stroke in young and middle-aged adults, causing up to 25% of all ischemic strokes in patients 15 to 49 years of age.\(^1\)\(^2\) Depending on the affected vessel, sCAD is divided into spontaneous internal carotid artery dissection (sICAD) and spontaneous vertebral artery dissection (sVAD). The causes of sCAD are poorly understood. Both constitutional and environmental factors play a role. In most studies, sICAD and sVAD were analyzed as one entity. Analogous to aortic dissection, in which pathologies differ between vessel segments,\(^1\) there might be differences in the mechanisms leading to sICAD and sVAD.

The Cervical Artery Dissection Ischemic Stroke Patients (CADISP) group recently reported significant differences between sICAD and sVAD.\(^5\) In light of these new findings, we aimed to compare the frequency of potential risk factors, presenting clinical characteristics, and outcome after 3 months in patients with sICAD and sVAD. Furthermore, we investigated whether time to diagnosis differed between sVAD and sICAD and changed over time. To answer these questions, we retrospectively compared patients with sICAD and sVAD enrolled in our ongoing database of 1027 patients with cervicocerebral artery dissection from 3 stroke centers.

Patients and Methods

Patients

In this observational study, we analyzed prospectively collected data of 1027 consecutive patients with a first-ever sCAD who were treated in 1 of the following 3 tertiary referral hospitals: University Hospital
Baseline Characteristics and Potential Risk Factors

Baseline characteristics and potential risk factors were assessed by a structured patient interview or reconstructed on the hospital reports. The following potential risk factors were collected: arterial hypertension, diabetes mellitus, hypercholesterolemia, former or present smoking, migraine with or without aura, current use of anticoagulation or hormone substitution, known connective tissue disorder, febrile infection or minor trauma within the past 4 weeks before sCAD, and family history of stroke, sCAD, or connective tissue disorder.

Arterial hypertension was defined as a positive history of treated or untreated hypertension (before 2000: systolic blood pressure >160 mm Hg or diastolic blood pressure >95 mm Hg; after 2000: systolic blood pressure >140 mm Hg or a diastolic blood pressure >90 mm Hg).

Hypercholesterolemia was defined by total venous fasting cholesterol values >5.0 mmol/L or treatment with cholesterol-lowering medication. Current smoking was defined as regular smoking within the past 5 years; former smokers abstained for ≥25 years. History of migraine with or without aura was assessed by a neurologist on the basis of International Headache Society criteria.12

Assessed connective tissue disorders included Ehlers–Danlos syndrome type IV, Marfan syndrome, and osteogenesis imperfecta type I. Family history of connective tissue disorder, sCAD, or ischemic stroke was considered positive if ≥1 first-degree relative was affected. Febrile infection was defined as ≥1 clinical symptom of infection and body temperature >38°C. Fibromuscular dysplasia was only assessed in patients who underwent digital subtraction angiography.

Clinical Presentation

At initial encounter, all patients underwent a neurological and physical examination by a trained neurologist (including a routine blood sampling and an ECG). Patients were screened for ischemic events (transient ischemic attack [TIA], stroke, amaurosis fugax, and retinal infarction) and local symptoms (neck pain, headache, thunderclap headache, Horner syndrome, pulsatile tinnitus, cranial nerve palsy, cervical radiculopathy, and cervical spinal cord ischemia). Severity of head or neck pain was assessed using the visual analogue scale.13

Horner syndrome and cranial nerve palsy were only recorded when not occurring in the context of a brain stem infarction. Ischemic symptoms were classified according to the duration of clinical symptoms: TIA and amaurosis fugax if <24 hours, stroke and retinal infarction if >24 hours.

In case of a cerebral stroke, the National Institutes of Health Stroke Scale (NIHSS) score was assessed and a cerebral MRI or computed tomography was performed. If the NIHSS score was not assessed, it was reconstructed from hospital reports. All patients received an evaluation of the cerebral and cervical arteries by MRI/MR angiography, ultrasound examination or digital subtraction angiography. Reversible cerebral vasoconstriction was defined according to Ducros et al,10 and its previously reported association with sCAD10,11 was further investigated in the present study.

Time to Diagnosis

We defined the onset of clinical symptoms on the basis of the first symptom, which the treating neurologist could associate with an sCAD. Time to diagnosis was defined as the time interval between the date of symptom onset and the date on which the neurovascular imaging leading to the diagnosis was performed.

Three-Month Follow-Up

A clinical follow-up (n=728) or structured telephone interview (n=82), which included the assessment of the modified Rankin Scale (mRS), was performed at 3 months. A total of 163 follow-ups (17%) were missing (proportionally equally in 112 patients with sICAD [17%] and 50 patients with sVAD [17%]). Recurrent events (dissection, stroke, TIA, and death) and current medication were registered.

Statistical Analysis

Demographic variables, potential risk factors, and clinical parameters were compared between sICAD (or multiple sICAD) and sVAD (or multiple sVAD). Mann–Whitney U-test, differences of categorical variables with χ² test, or Fisher exact test, if appropriate. Hormonal anticonception was only assessed in women <50 years of age. Multivariate logistic regression analysis was performed to evaluate an independent association among baseline characteristics, potential risk factors, clinical symptoms, and diagnosis of sVAD versus sICAD. The following variables were included: age, sex, center of inclusion, NIHSS score, neck pain, thunderclap headache, pulsatile tinnitus, and subarachnoid hemorrhage (SAH). The cutoff for inclusion in the multivariate analysis was P<0.1 in the univariate analysis. Confidence intervals (95%) were calculated.

To determine the diagnostic delay, we performed a subgroup analysis dividing all sCAD into 2 groups: (1) diagnosis of sCAD between 1997 and 2000, and (2) diagnosis of sCAD between 2001 and 2012. To compare the 3-month follow-up, we dichotomized the clinical outcome measured by the mRS into 2 groups: good outcome (mRS, 0–2) and poor outcome (mRS, 3–6). We ran a logistic regression analysis correcting for center of inclusion, age, sex, NIHSS score, and site of dissection to determine an independent association between the affected vessel and the outcome.

Results

Baseline Characteristics and Potential Risk Factors

Of 970 patients (59.7% men), 668 (68.9%) presented with unilateral or bilateral sICAD and 302 (31.1%) with unilateral or bilateral sVAD (Table 1).

Patients with sICAD were more often men (62.7% versus 53.0%; P=0.004) and older (46.3±9.6 years versus 42.0±10.2 years; P<0.001; Table 1). Bilateral dissection occurred half as often in patients with sICAD compared with sVAD (7.6% versus 15.2%; P<0.001). Current smoking was significantly less frequent in sICAD than in sVAD (28.7% versus 36.0%; P=0.02). No other investigated potential risk factor showed a different association between sICAD and sVAD in univariate analysis. A total of 35 sCAD were isolated intracranial dissections. Of all 668 sICAD, 6 were isolated intracranial (0.9%); of all 302 sVAD, 29 were isolated intracranial (9.6%). After performing multivariate analysis, the higher frequency...
of sICAD in men compared with women lost its significance (P=0.21); all other variables showed an independent, significant association (Table 1).

### Clinical Presentation

Patients with sVAD presented twice as often with neck pain (65.8% versus 33.5%; P<0.001), but neck pain intensity was not significantly higher compared with sICAD (visual analogue scale, 6.5±1.9 versus 6.0±1.7; P=0.12; Table 2). However, headache was equally common in both (sVAD 70.4% versus sICAD 71.4%; P=0.77) but significantly stronger in its intensity in sVAD (visual analogue scale, 7.5±2.1 versus 6.7±1.8; P<0.001). Thunderclap headache occurred more than twice as often in sVAD than in sICAD (9.2% versus 3.6%; P=0.001). Of the 24, 10 patients with thunderclap headache had an SAH. Patients with sVAD were 10 times more often affected by SAH than patients with sICAD (6.0% versus 0.6%; P<0.001). Of the 18, 4 patients with sVAD-related SAH were associated with reversible cerebral vasospasm syndrome. Apart from cranial nerve palsies and Horner syndrome, which only appear in carotid artery dissections, pulsatile tinnitus was the only symptom that presented significantly more often in patients with sICAD than in sVAD (10.9% versus 3.4%; P<0.001).

Cerebral ischemic events (ie, stroke, TIA, retinal infarction, or amaurosis fugax, combined) affected patients with sVAD significantly more often than patients with sICAD (84.4% versus 70.4%; P<0.001). Ischemic stroke was significantly more frequent in sVAD (69.5% versus 52.2%; P<0.001), but less severe than in sICAD (mean NIHSSVA D 5±5.9 versus NIHSSsICAD 10±7.1; P<0.001). Rare findings were spinal infarction (C2-4) in 1 patient and cervical radiculopathy (C5-7) in another, both associated with sVAD. One patient with sICAD was asymptomatic.

### Clinical Outcome and Recurrence

Clinical outcome measured by mRS was significantly better in patients after sVAD than after sICAD (mRS, 0–2: sVAD 88.8%, sICAD 58.4%; P<0.001; Table 3). There was a trend toward higher mortality after sICAD within
the first 3 months after dissection ($P=0.059$) in univariate analysis.

Seven patients (0.9%) had a recurrent isolated dissection, none of them after a multiple dissection. The amount of recurrent dissections did not differ between sICAD and sVAD, but 4 of the 5 recurrent dissections after sICAD affected the vertebral artery, whereas 1 of the 2 recurrent dissections after sVAD affected the contralateral vertebral artery, and the other one affected both the internal carotid and the contralateral vertebral artery. Recurrent TIA and stroke were more common after sVAD (TIA: sVAD 4.8%, sICAD 1.1%, $P=0.001$; stroke: sVAD 2.8%, sICAD 0.7%, $P=0.02$).

Multivariate analysis was performed adjusting for age, sex, center of inclusion, NIHSS score, and site of dissection to determine an independent association between the affected vessel and outcome. Only the higher baseline NIHSS score was highly associated with a poor outcome ($P<0.001$) and higher mortality ($P<0.001$).

### Discussion

This is the second large study analyzing differences in baseline characteristics, clinical symptoms, potential risk factors, and outcome between sICAD and sVAD.

### Baseline Characteristics and Risk Factors

The frequency of sICAD was about twice as high compared with sVAD, which is in line with previous findings.\textsuperscript{12,13} In agreement with previous studies, bilateral dissection affected the vertebral artery twice as often as the internal carotid artery.\textsuperscript{5,14} Patients with sICAD were older and more often men, compared with patients with sVAD, which is consistent with previous findings.\textsuperscript{5,13–15} These age and sex differences are difficult to explain. However, because patients with sVAD were younger compared with patients with sICAD, it is possible that risk factors or triggering events, such as traumas that are less related to advanced age, are involved more in the pathogenesis of sVAD than sICAD. Of interest, younger age at CAD onset and multiple CADs have been reported to be more common in women.\textsuperscript{16–18} These differences in age and sex may suggest that genetic differences, sexual hormones, or even sex-related differences in arterial wall properties may play a role.\textsuperscript{19,20} Moreover, the vertebral artery and the carotid artery do have a different embryological origin.\textsuperscript{5,21} Of interest, current smoking was more frequent in patients with sVAD. This result is in line with the observation that smoking was associated with dilatation of only the thoracic aorta, which has the same embryological origin as the vertebral artery, and not of the ascending aorta, which has the same roots as the internal
could be found.5,14

ence in previous febrile infection or minor cervical trauma
ischemic strokes in the posterior circulation.23–25
compared with sV AD. Ischemic strokes in the anterior
circulation of undefined pathogenesis have previously been
explained by the anatomic proximity of the typical location
of ICAD to the inner ear. Two patients with sV AD presented
with rare manifestations: 1 patient with a cervical radiculopa-
thesis of sICAD between 2001 and 2012 compared with the
find a significant diagnostic delay of sV AD compared with
syndrome or lower cranial nerve palsies. Hence, the diag-
with those of sICAD, which are typically a painful Horner
score, which was higher in patients with stroke because of
stroke. After multivariate analyses, the only parameter inde-
pendently predicting functional outcome was the NIHSS
stroke. who experienced an sICAD-related stroke was significantly
less common compared with patients with an sVAD-related
stroke. We observed a nonsignificant trend toward higher mortality in patients with an sICAD-related
ischemic stroke.

Clinical Outcome and Recurrence
In univariate analysis, a good outcome (mRS, 0–2) in patients
who experienced an sICAD-related stroke was significantly
were mostly located in the vertebral artery, no matter whether
the initial dissection affected the vertebral or carotid artery,
which to our knowledge, has not been previously reported.
Only 1 recurrent dissection affected the same vessel on the
same side again.
Both recurrent TIA and recurrent ischemic stroke were
more common after sV AD. We observed a nonsignificant trend
toward higher mortality in patients with an sICAD-related
ischemic stroke.

Strengths and Limitations
Strengths of this study are the large sample size and the signifi-
cant results after correction for multiple comparisons. Because
of the low incidence of sCAD in the general population, we
had to include patients over a long time period and from 3 dif-
ferent centers. The centers of inclusions consisted only of uni-
versity hospitals. Thus, a selection bias with more severe cases,
especially more patients with strokes, might have occurred and
patients with only local symptoms might have been underrep-
resented. In addition, one-sixth of the patients had no 3-month
follow-up examination. However, the rate of patients with lost
follow-up did not differ between sVAD and sICAD patients.

Conclusions
Although patients with sICAD and sVAD have many features
in common, they differ in age, clinical presentation, risk fac-
tors, outcome, and rates of early recurrent ischemic events.
The observed differences do not provide enough evidence to
propose different treatment strategies for sVAD and sICAD.
However, future studies on sCAD should perform separate
analyses of the 2 entities.

Table 3. Three-Month Follow-Up: Outcome and Events According to Dissection Site (sICAD vs sVAD)

<table>
<thead>
<tr>
<th></th>
<th>All Patients</th>
<th>sICAD</th>
<th>sVAD</th>
<th>P Univariate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Rankin Scale 0–2 (patients with ischemic stroke), n (%)</td>
<td>293 (70.1)</td>
<td>150 (58.4)</td>
<td>143 (88.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Recurrent dissection, n (%)</td>
<td>7 (0.9)</td>
<td>5 (0.9)</td>
<td>2 (0.8)</td>
<td>0.999</td>
</tr>
<tr>
<td>Recurrent TIA, n (%)</td>
<td>18 (2.3)</td>
<td>6 (1.1)</td>
<td>12 (4.8)</td>
<td>0.001</td>
</tr>
<tr>
<td>Recurrent stroke, n (%)</td>
<td>11 (1.4)</td>
<td>4 (0.7)</td>
<td>7 (2.8)</td>
<td>0.021</td>
</tr>
<tr>
<td>Death, n (%)</td>
<td>15 (1.9)</td>
<td>12 (2.4)</td>
<td>2 (0.8)</td>
<td>0.162</td>
</tr>
<tr>
<td>Death (patients with ischemic stroke), n (%)</td>
<td>14 (3.3)</td>
<td>12 (4.7)</td>
<td>2 (1.2)</td>
<td>0.058</td>
</tr>
</tbody>
</table>

sICAD indicates spontaneous internal carotid artery dissection; sVAD, spontaneous vertebral artery dissection; and TIA, transient ischemic attack.

carotid artery.4,21 Diverging from previous findings, no differ-
ence in previous febrile infection or minor cervical trauma
could be found.5,14

Clinical Presentation
A new finding is that thunderclap headache was more than
twice as common in sVAD compared with sICAD, which is
only partly explained by a higher amount of SAH in sVAD.
The reasons for this association remain unknown.

Pulsatile tinnitus, which corresponds to noise evoked by
turbulent, nonlaminar blood flow and transmitted to the inner
ear,22 occurred thrice more often in sICAD. This may be
explained by the anatomic proximity of the typical location
of ICAD to the inner ear. Two patients with sV AD presented
with rare manifestations: 1 patient with a cervical radiculopa-
thy and another with a cervical spine infarction.

In agreement with the CADISP study,4 ischemic stroke
was less frequent but more severe in patients with sICAD
compared with sVAD. Ischemic strokes in the anterior
circulation of undefined pathogenesis have previously been
reported to cause a more severe impairment compared with
ischemic strokes in the posterior circulation.23–25

A 10-fold amount of patients with sVAD experienced an
SAH compared with patients with sICAD. Most of them
affected either only the intracranial segment of the verte-
bral artery or extended to the intracranial segments. Of the
18, 4 patients with sVAD-related SAH were associated with
a reversible cerebral vasoconstriction syndrome, which is
known to cause SAH in some patients without evidence for
intracranial extension of the cervical artery dissections and
which was diagnosed in 12 patients in total.11

Time to Diagnosis
Local clinical symptoms of sVAD are not specific compared
with those of sICAD, which are typically a painful Horner
syndrome or lower cranial nerve palsies. Hence, the diag-
nosis of sVAD poses a challenge. However, we could not
find a significant diagnostic delay of sVAD compared with
sICAD. An interesting observation is the earlier diagno-
sis of sICAD between 2001 and 2012 compared with the
diagnosis made between 1990 and 2000. This indicates a
diagnostic improvement, probably because of a progress in
imaging modalities and an increased awareness of the dis-
ease. In sVAD, no diagnostic improvement in the later time
period could be shown. This points out that there is still
much room for improvement of the clinical and diagnostic
work-up in sICAD.
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References
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