COMMENT

Epistaxis complicating a severe head injury is not unusual but when it occurs weeks later its direct relation to the injury is not so apparent.

The differential diagnosis of a neoplasm, arteriovenous fistula or aneurysm was greatly simplified by the right carotid arteriogram which showed a saccular midline aneurysm located anteroinferior to the sella.

The term aneurysm is used because of the density of its contained dye, globoid outline, sharply defined margins, the lack of a venous exit, and its continuity with the internal carotid artery.

The routine lateral and anteroposterior arteriogram views at first suggested an origin from the right internal carotid artery. In an attempt to better define the neck of the aneurysm a left anterior oblique view was made; this revealed an unusually long narrow stalk which was taken to be the ophthalmic branch (Fig. 3).

The ophthalmic artery in this instance arose quite far posteriorly in the cavernous sinus rather than at its usual site of origin at the anterior genu of the internal carotid.

Revascularization of this “trapped” aneurysm via the ophthalmic artery was felt to be unlikely in view of the cessation of pulsation in the isolated segment of the internal carotid artery.

In this particular case the coincidence of the blindness, optic atrophy and aneurysm of the ophthalmic artery following the accident suggests the possibility of an unrecognized fracture involving the lesser wing of the right sphenoid, optic foramen and adjacent sphenoid sinus.

SUMMARY

1. A case of traumatic aneurysm of the ophthalmic artery is summarized.
2. The use of an oblique view in angiography to accurately identify the origin of this aneurysm is illustrated.
3. Indirect control of the aneurysm is outlined.

REFERENCES


TRANSIENT LOSS OF VISION FOLLOWING CEREBRAL ARTERIOGRAPHY

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Not a few descriptions of the various complications of cerebral arteriography may be found in the literature, but those related to disturbance of vision have been rare. The authors deem it worth while to record a case in which there was marked reduc-
tion in vision on the injected side within 2 hours of arteriography and complete recovery within 48 hours. The development and course of this phenomenon appeared to be directly related to the arteriographic procedure.

CASE REPORT

J. H. H. No. 591170. A 51-year-old white male from Texas was admitted on the service of Dr. Benjamin M. Baker with hemiparesis of 2 years’ duration. The family history was not remarkable except that the patient’s mother had been diabetic, although the cause of her death was unknown. The past history was not contributory.

At the age of 40 years, or 11 years before admission, the patient had an episode of left facial palsy, weakness of the left arm, and pain in the left side of the neck. These symptoms lasted only half a day, then disappeared completely; but following that episode he had noted loss of temperature appreciation on the left side of his body.

In May 1949, or 9 years later, he had weakness of the 4th and 5th fingers of his left hand lasting for 2 or 3 days. In June 1949, he awoke one morning and found his left arm paralyzed. Within the next 3 days a flaccid hemiplegia developed, without involvement of the face and with no headaches or loss of consciousness. During the following 6 months strength returned gradually, walking was resumed, and it became possible for him to use the arm and hand to a surprising extent.

In October 1951, 1 month prior to admission, he began to stagger one day and his tongue became awkward but within 12 hours these symptoms disappeared.

Examination. On admission, temperature, pulse, and respiration were normal. Blood pressure was 136/82. He appeared quite healthy but slightly overweight. The eyes, ears, nose, and throat were normal. The thyroid was not felt and there was no lymphadenopathy. Lungs were clear to percussion and auscultation. The heart was normal in size and the rhythm was good. No murmurs or irregularities were noted. The abdomen was soft, somewhat protuberant, and the liver, kidneys and spleen were not palpable. The prostate was normal in size and consistency. Peripheral blood vessels did not seem sclerotic.

Neurologic examination revealed that the pupils were equal, round, and reacted well to light, accommodation and consensual stimulation. There was a full range of ocular motility and nystagmus was not observed. The optic discs were flat, with sharp neuroretinal margins and distinct laminae cribrosae. Retinal vessels were not noticeably narrowed. Facial movements were symmetrical and facial sensation was normal to testing. He walked with some difficulty, dragging the left leg slightly, while associated coordinated movements in the left arm were lacking. Muscular tone seemed equal on both sides but strength was moderately decreased on the left. Tendon reflexes were exaggerated on the same side, and the plantar response was extensor on the left. Abdominal reflexes were present and equal. Clonus was not elicited, nor was the Hoffmann sign. Finger-nose and heel-knee tests were poorly executed on the left, while fine movements were not possible with the left hand. Sensory examination revealed hypesthesia and hypalgesia with impaired temperature appreciation over the left side of the body below the clavicle. Vibratory and position sense, however, were unaffected, and the Romberg sign was negative.

Laboratory Data. Hb. 16.0 gm. WBC 6100 with normal differential. Erythrocytes and platelets normal on smear. Sedimentation rate 18 mm. (corrected). Icterus index 3.0. NPN 30.0. Blood cholesterol 306. Urinalysis revealed a trace of albumin. X-rays of the skull were normal.

Arteriography. On Nov. 26, 1951, percutaneous carotid arteriography was performed on the right side under local anesthesia. One hour previously, he had been given phenobarbital (96 mg.) and demerol (150 mg.) subcutaneously. The preliminary conjunctival sensitivity test using 2 drops of diodrast (35 per cent) was negative. Stellate ganglion block with 1 per cent procaine was carried out prior to dye injection and a good Horner’s syndrome developed. Carotid puncture was done two fingers above the clavicle and performed without difficulty. A good exchange was obtained. Four injections of 15 cc. each (total 60 cc.) of 35 per cent dio-