Pulsatile Proptosis: Think About the Carotid-Cavernous Fistula

Ayman El Farouki1*, Hassan Douhousni2, Habib Bellamlhil3, Soufiane Belabbes4

1Radiology Department, 5th Military Hospital -Guelmim
2Radiology Department, 4th Military Hospital -Dakhla
3Radiology Department, Moulay Ismail Military Hospital, Meknes, Morocco

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*Corresponding author: El Farouki A

Abstract

Carotid-cavernous fistula is an abnormal communication between the cavernous sinus and the carotid arterial system. The clinical presentation is dominated by pulsatile proptosis. We report the case of a 31-year-old man who presented with a recent onset of pulsatile proptosis. A cerebral angiography scan revealed a left-sided dilation of the cavernous sinus veins due to a direct carotid cavernous fistula. The patient was referred to radiology department where and endovascular approach was performed.

Keywords: Pulsating proptosis, Carotid-cavernous fistula, Carotid artery, Cavernous sinus, CT-angiography.

INTRODUCTION

Carotid-cavernous fistula (CCF) is an abnormal communication between the cavernous sinus and the carotid arterial system [1]. It is a rare pathology occurring most often after a traumatic event [2]. The clinical presentation is dominated by pulsatile proptosis [3]. However, it can remain unrecognized for a long time and diagnosed at a late stage involving the vital and visual prognosis [4]. We present the case of a young 31-year-old patient with post-traumatic carotid-cavernous fistula revealed two months after the craniofacial traumaism.

CLINICAL CASE

A 31-year-old man presented to the ophthalmology department with a recent onset of proptosis. He was the victim of a head trauma two months earlier. Initial imaging did not show any bone lesion. The consequences were marked by the onset of tinnitus, with left proptosis and chemosis without loss of visual acuity. Clinical examination found a ptosis with dilation of the episcleral veins and left pulsatile proptosis and thrill on palpation (ERROR! REFERENCE SOURCE NOT FOUND.). A cerebral Angio CT-scan was performed (Fig-2) which revealed an important dilation of the cavernous sinus veins (Fig-2 A). It also shows a dilation and opacification in the arterial phase of the superior ophthalmic vein (SOV) (Fig-2 B), preptonic, peribulbar (Fig-2 D) and cortical veins (Fig-2 C). The venous sinuses were opacified in the arterial phase (Fig-2 D). We also noted an oculomotor muscles thickening associated to a grade B proptosis (Fig-2 A).

DISCUSSION

Carotid-cavernous fistula (CCF) is an abnormal communication between the carotid arteries and the cavernous sinus [1]. It is a rare condition which can be spontaneous or post-traumatic [5]. Direct or high-flow (Type A) CCFs results from a direct shunt between the internal carotid artery and the cavernous sinus [1]. They are most often post-traumatic and concern 0.2% of patients with head trauma [3]. In 24% of cases, they can result from a rupture of an intracavernous internal carotid aneurysm [3]. Low-flow dural fistulas can be supplied by the intracavernous branches of the internal carotid artery (Type B), or the external carotid artery (Type C) or from both the internal and external carotid branches (Type D) [1] (Fig-3).

The clinical signs are dominated by the ophthalmologic manifestations, mainly the exophthalmos which is unilateral and pulsatile [4]. It may be associated with chemosis or oculomotor palsy [3].

In some patients proptosis and conjunctival chemosis may be lacking, in these cases their absence is explained by the multicompartamental character of the cavernous sinus, with the absence of connection with the ophthalmic vein. The blood is drained to petrousafb
sinuses, cortical veins, and less frequently to the preptonic or spinal veins which can cause a spinal cord compression [1].

Brain CT or MRI can visualize indirect signs of CCF [4]. They confirm proptosis, objectify the thickening of the intra-orbital muscles, with an enlargement of the cavernous compartment and a dilation of the superior ophthalmic vein. Angio-CT scan confirms the arteriovenous shunt with opacification in the arterial phase of the veins of the cavernous sinus, the ophthalmic veins and the petrous sinuses [6].

Color Doppler provides arguments for the diagnosis by showing an inverted Doppler signal with systolic strengthening in the SOVs [4].

Arteriography is the key in the management of CCF. It allows firstly to confirm the diagnosis and characterize the fistula, and secondly to treat the CCF [4]. In fact, treatment of CCF is urgent because of the risks associated with intracavernous venous hyperpressure, involving the functional and vital prognosis. It is based on the closure of the arteriovenous communication, by balloon or coils, more recently by reconstruction of the damaged carotid wall with a covered stent or even by carotid occlusion [7].

The efficacy is immediate on pulsatile exophthalmos; recovery of oculomotricity is later [4].

**CONCLUSION**

Pulsatile exophthalmos is the most suggestive clinical finding of a carotid-cavernous fistula and should lead to the realization of a cerebral angio-CT scan which may show signs of CCF. The arteriography should not be delayed; it will confirm the diagnosis of CCF and permit the treatment of the CCF.
A-Dilation and opacification in the arterial phase of the left cavernous sinus veins associated to a thickening of oculomotor muscles, B-Dilatation of the superior ophthalmic vein, C- Dilation of the cortical veins, D- Opacification in the arterial phase of the cerebral venous sinuses associated to a dilatation of prepontic and peribulbar veins.

Fig-3: Barrow classification of CCFs [8]

REFERENCES