BASILAR ARTERY THROMBECTOMY

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History and Physical

76 years old female with history of TIA in 2011 (left hemisyndrome), daily aspirin (100 mg.) user with no disability (mRS - 0) before the onset of symptoms. Symptoms 2 hours before hospitalization: interrupted speech and coordination, nausea, vomiting, right hemiparesis.

Imaging

CT angiography revealed thrombus in the basilar artery tip (Figure 1A), occluding left posterior cerebral artery (PCA).

Indication for Intervention

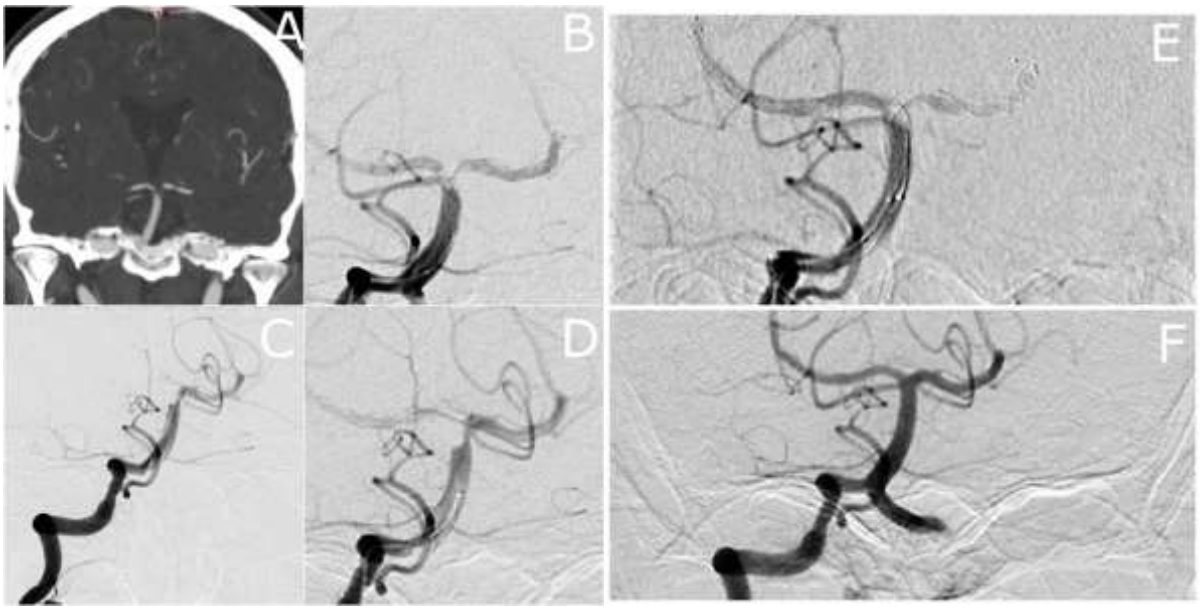
Acute occlusion of vertebrobasilar trunk with deteriorating patient status.

Intervention

Right vertebral artery was cannulated with 7F guiding catheter (Mach 1) and a Trevo 4x30mm revascularization device was deployed across the basilar occlusion into the left PCA (Figure 1B). After the first extraction flow was restored to the left PCA, but the round, well agregated thrombus was still there, now occluding the right PCA (Figure 1C). Revascularization device was deployed in contralateral PCA and still no result after the 2-nd thrombectomy (5 min. of waiting, “massage” technique was applied). Third session (stentriever deployed over the thrombus - no place to escape) supposed to be the last one (Figure 1D), but still no result and just after 4-th session, when another Trevo 6x25mm was simultaneously deployed in contralateral PCA (Figure 2E) - thrombus was trapped by double retriever extraction (Figure 2F).
CT after thrombectomy: only tiny ischemia in the right cerebellar hemisphere.

Learning Points of the Procedure

Vertebrobasilar occlusions requires the most effective technique available.
Thrombus aggregation level can be a (not)success key factor of the procedure, especially if you relay on a single technique.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