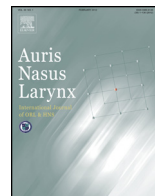




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A case of vertebral artery aneurysm presenting with dysphagia

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ABSTRACT

Here, we report a case of vertebral artery aneurysm causing dysphagia in a 56-year-old man who had no remarkable past history. Two months before the first visit, he developed posterior neck pain followed by difficulty swallowing 1 month later. He was referred to our clinic because of gradually worsening dysphagia. Physical examination showed paralysis of cranial nerves IX, X, and XII; therefore, he was hospitalized. Because enhanced CT and MRI showed a partially thrombosed right vertebral artery aneurysm, he was transferred to the care of the Department of Neurosurgery. Parent artery occlusion of the right vertebral artery aneurysm was performed and it improved his symptoms. After regaining his ability to take in liquid food, he was transferred to another hospital for further rehabilitation. In this case, we attributed the dysphagia to aneurysmal compression of the roots of cranial nerves IX, X, and XII. A partially thrombosed cerebral artery aneurysm may often rupture and cause worsening of neurologic symptoms. The prognosis is generally poor because the rupture rate is extremely high especially with large or giant aneurysms. However, this case had a good clinical course owing to treatment by parent artery occlusion.

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1. Introduction

Dysphagia is defined as a symptom of difficulty or abnormality of swallowing, and suggests the presence of an organic abnormality in the passage of solids or liquids from the oral cavity to the stomach. It is a common symptom so doctors of different specialties, including physicians, oral surgeons, and otolaryngologists, examine patients with dysphagia. Most patients who visit otorhinolaryngology clinics complaining of dysphagia usually have no abnormal findings, but we sometimes have difficulty treating dysphagia that accompanies head and neck cancer and that occurs after surgery or

chemoradiotherapy. In general hospitals, a large proportion of patients with dysphagia have underlying neurologic disease. In particular, dysphagia occurs in approximately 42–51% of stroke patients [1–3]; therefore, we must always consider not only organic diseases of the pharyngolarynx, but also intracranial lesions in patients with dysphagia.

The prevalence of unruptured cerebral aneurysm in individuals with a mean age of 50 years is 3.2% [4] and aneurysm of the vertebral or posterior inferior cerebellar artery accounts for 7.6% of all cerebral aneurysms; vertebral artery aneurysm is thus a relatively rare disease [5]. Usually, vertebral artery aneurysms are detected as either subarachnoid hemorrhage during a health checkup or due to development of focal symptoms. According to Yamaura et al., subarachnoid hemorrhage accounts for 67% of aneurysm cases, incidental health checkup findings for 6%, and development of focal symptoms such as dysphagia due to

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a mass effect for another 6% [6]. Andoh et al. [7] reported that 33 cases (87%) of vertebral artery aneurysm were found because of subarachnoid hemorrhage and 1 case (3%) was due to focal symptoms. Therefore, most vertebral artery aneurysms are found because of the development of subarachnoid hemorrhage.

Here, we report a case of vertebral artery aneurysm that caused dysphagia as a focal symptom.

2. Case

The patient was a 56-year-old man who presented with a chief complaint of dysphagia. Two months prior to the first visit, he started to develop posterior neck pain. One month later, he started to experience soft food getting stuck in the back of his throat, which progressed to difficulty in swallowing immediately before his visit. Dysarthria developed and worsened gradually during the same period. He visited a nearby internist and upper gastrointestinal endoscopy was performed, but it did not reveal any abnormality. Thereafter, he had difficulty drinking water. He was referred to our clinic for further examination by a nearby otolaryngologist.

The patient had no remarkable past history. He had a history of tobacco use of 4 packs per day for 31 years and drank beer

(350 ml) 3 times a week for 31 years. His father had lung carcinoma.

At the first visit at our clinic, oral retention of saliva and weak soft palate elevation on the right were observed. The curtain sign was positive, with deviation to the left. Lingual atrophy and deviated tongue protrusion were noted on the right. In addition, he had dysarthria, characterized by slurred speech accompanied by rhinolalia aperta. Laryngoscopy revealed incomplete right-sided vocal cord paralysis with remarkable salivary and sputum retention. No tumorous lesions were observed. We did not conduct videoendoscopic examination of swallowing because he could not swallow even saliva by himself and was at high risk of aspiration.

The patient was then admitted to our hospital. Based on the above findings, a neurologic disorder was suspected and we referred him to the Department of Neurology. Considering the risk of aspiration, we restricted oral feeding and started him on tube feeding. To evaluate the pharyngolaryngeal and intracranial abnormalities, emergent enhanced computed tomography (CT) scan was performed and revealed a mass (25 mm at widest diameter), located anterior to and compressing the medulla oblongata (Fig. 1A). The right vertebral artery appeared to penetrate the mass, which was later regarded as aneurysmal dilatation of the right vertebral artery.

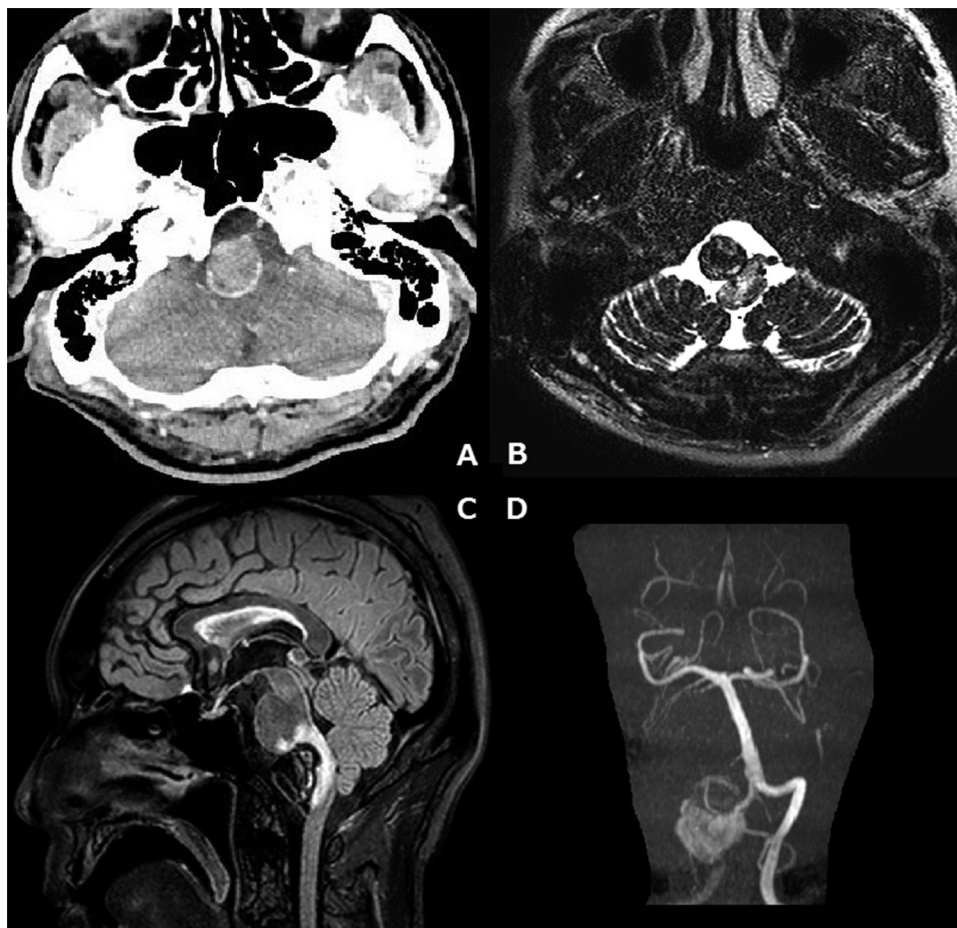


Fig. 1. (A) Enhanced CT scan revealed a mass (25 mm widest diameter) anterior to and compressing the medulla oblongata. The right vertebral artery penetrated the interior of the mass, which was later regarded as an aneurysm of the right vertebral artery. (B) T2-weighted MRI showed a similar mass that compressed the medulla. (C) FLAIR of MRI showed a high-intensity area of the brain stem around the aneurysm, suggesting edematous change. (D) MRA showed an aneurysm of the right vertebral artery with decreased blood flow within the aneurysm.

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