Brainstem Congestion due to Dural Ateriovenous Fistula at the Craniocervical Junction

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INTRODUCTION

Spinal dural arteriovenous fistula (SDAVF) is the lesion within dural leaflets due to direct arterial-to-venous shunt. Dural arteriovenous fistula (DAVF) at the craniocervical junction is rare, as an uncommon type of SDAVF which has been documented in several case reports.²⁻⁴ Cases usually present with subarachnoid hemorrhage (SAH) or myelopathy. We report a patient who presented brainstem dysfunction due to DAVF at the craniocervical junction that was cured by transarterial Onyx embolization. It is a very rare case when symptoms are caused by abnormal venous drainage. On the other hand, Onyx embolization for DAVF in this area has rarely been described. Drainage patterns should be paid attention to because they are important for diagnosis and therapeutic strategy.

Key Words: Dural arteriovenous fistula · Brainstem dysfunction · Diagnosis · Venous congestion.

CASE REPORT

A 46-year-old female patient presented with a history of one month’s duration of vertigo, gait, nausea, vomiting and dysphagia, which developed progressively. Head computed tomography scan revealed a low density lesion at the brainstem. She was referred for a brain MRI study with a preliminary diagnosis of brainstem infarction in a local hospital. T2-weight MRI and FLAIR image showed high signal intensity swelling from pons to medulla oblongata (Fig. 1A, B). Low signal intensity and partial enhancement in the same territory were detected on T1-weight and contrast enhanced imagings (Fig. 1C). The patient was transferred to our hospital. Neurologic examination revealed attenuation of left-side gag reflex and right-side nasolabial groove. Tongue extension moved to the right and muscular strength of left limbs was IV in this case. Left-side finger-to-nose test was positive. Spinal MRI disclosed abnormal flow void at ventral surface from craniocervical junction to cervical cord, suggesting engorged vessels (Fig. 1D). Cerebral angiography performed five days after admission revealed DAVF with a meningeal branch originated from the radicular artery of the right C2 segment of VA as a feeding vessel, draining via abnormally hypertrophic pontomesencephalic veins ascending into basal vein retrogradely and descending into the anterior spinal vein, anterior internal vertebral venous plexus and vertebral artery venous plexus (Fig. 2A, B). Arterial feeder originated from external carotid artery (ECA) was not disclosed from bilateral ECA.
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complete obliteration of the fistula and disappearance of abnormal venous drainage (Fig. 2D). MRI did not demonstrate any abnormalities in the brainstem (Fig. 3).

DISCUSSION

SDAVF is a common type of spinal vascular malformation in adult that usually affects the lumbar or lower thoracic spine. This is uncommon at the craniocervical junction. Review of the literature revealed that DAVFs occurring at the craniocervical junction had been called DA VFs at the foramen magnum and often present with progressive myelopathy or SAH. Only one case in this anatomical area has been reported to involve brainstem dysfunction. Brainstem dysfunction as an initial symptom has been documented in several cases of CCFs or intracranial DAVFs. Congestion caused by venous hypertension was also considered as a probable pathological mechanism.

In here we describe a case presenting with brainstem dysfunction at onset. Symptoms developed progressively for one month. This onset was different to brainstem infarction whose progression is acute or subacute. An MRI study detected abnormal flow void, suggesting engorged vessels. A cerebral angiogram confirmed a DAVF at the craniocervical junction that was supplied by the meningeal branch originated from the radicular artery of the right VA with ascending and descending venous drainage.
DAVF ought to be considered for these dysfunctions to avoid catastrophic outcomes such as brainstem hemorrhage or necrosis which might result from erroneous diagnosis followed by incorrect therapy. Brainstem venous congestion may be caused by elevated venous pressure secondary to arterial pressure via fistula. In previously reported cases of SDAVFs, three major anomalous venous drainage patterns were recognized: ascending, descending and undetected. Ascending venous drainage into intracranial sinus was considered to account for SAH caused by venous hypertension. Moreover, a descending venous drainage was considered for myelopathy. Ascending along with descending venous drainage was detected in the present case, resulting in dysfunction due to brainstem congestion. The previous two cases of cervical DAVFs and one of lumbar spinal DAVF that presented brainstem dysfunctions demonstrated a similar ascending venous drainage (Table 1). The pathological mechanism is thought to involve blood flow of the venous drainage. Venous system of the brainstem is complicated because of the anastomosis between each other. Venous flow drains into the transverse sinus, the petrosal sinus and the straight sinus under normal physiological conditions. In a retrograde ascending venous drainage system of the cervical DAVF if the venous flow increases precipitously, an elevated hemodynamic stress, varix formation or even hemorrhage may occur. However, this patient and the other three cases reported with ascending drainage presented brainstem dysfunction rather than hemorrhage (Table 1). We found that retrograde flow in each case was slow and the draining volume was not very high. Under this condition, normal brainstem venous drainage would be stagnant, resulting in congestion and edema, similarly to myelopathy caused by venous hypertension as it is seen in some cases of SDAVFs. Therefore, the aim of treatment is to obliterate abnormal shunt and venous drainage as well as relieving venous congestion.

Onyx, as a novel liquid embolic agent, has been an alternative option in the treatment of cerebral and spinal vascular malformations. Surgical approach would be difficult and at high risk when the fistula and draining veins are located at the ventral side of the foramen magnum. This patient was treated with endovascular treatment using transarterial Onyx embolization, which is safer and more controllable than former endovascular therapeutic approaches. Onyx-18 was injected with a “hold-reinjection” technique to avoid glue migration to the proximal trunk of the feeding artery under real-time digital subtraction fluoroscopic mapping. Complete obliteration of the fistula was achieved; meanwhile, anomalous venous drainage disappeared. Anticoagulant and antiplatelet therapy were performed to prevent thrombosis caused by blood flow stasis in the arterialized drainage vein due to closure of a fistula. This patient recovered completely without any neurological deficits as determined during the follow-up period. Brainstem anomalous signals of T1-weight, T2-weight and contrast-enhanced T1-weight imaging had disappeared by the latest MRI study, which verified the lesion congestion rather than infarction.

**CONCLUSION**

Retrograde ascending venous drainage of the DAVF at the cranio-vertebral junction, when venous flow is not high, may induce brainstem venous congestion. Congestion could be reversible if DAVF is considered as a differential diagnosis for brainstem dysfunction of undetermined origin and appropriate treatment was performed promptly to avoid poor outcomes. Moreover, onyx embolization is an alternative option for the treatment of DAVF at the cranio-vertebral junction.

Table 1. Summary of case reports of brainstem venous congestion due to SDAVF

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age/gender</th>
<th>Location of dysfunction</th>
<th>Location of fistula</th>
<th>Venous drainage</th>
<th>Sinus drainage</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kulwin et al.</td>
<td>54/F</td>
<td>Pons</td>
<td>C2</td>
<td>SPV</td>
<td>NM</td>
<td>Surgical disconnection</td>
<td>Improved</td>
</tr>
<tr>
<td>Terao et al.</td>
<td>69/M</td>
<td>Medulla</td>
<td>C7</td>
<td>SPV</td>
<td>NM</td>
<td>Coil embolization, surgical disconnection</td>
<td>Improved</td>
</tr>
<tr>
<td>Wu et al.</td>
<td>70/M</td>
<td>Medulla</td>
<td>L1</td>
<td>SPV</td>
<td>NM</td>
<td>Embolization</td>
<td>Dead</td>
</tr>
<tr>
<td>Present case</td>
<td>46/F</td>
<td>Pons, medulla</td>
<td>C2</td>
<td>BV, ASV, AIVVP, VAVP</td>
<td>Straight sinus</td>
<td>Onyx embolization</td>
<td>Recovered completely</td>
</tr>
</tbody>
</table>

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References

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