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·临床医学图像·

巨大占位型颅内夹层动脉瘤

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Giant space-occupying intracranial dissecting aneurysm

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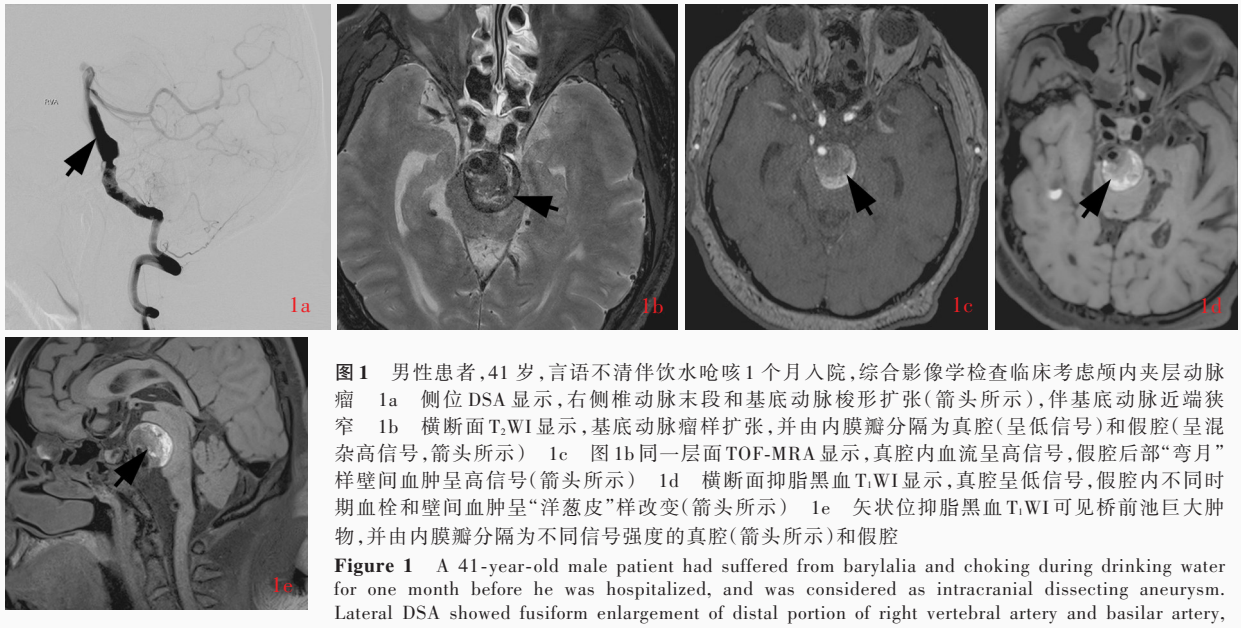

图1 男性患者,41岁,言语不清伴饮水呛咳1个月入院,综合影像学检查临床考虑颅内夹层动脉瘤 1a 侧位DSA显示,右侧椎动脉末段和基底动脉梭形扩张(箭头所示),伴基底动脉近端狭窄 1b 横断面T_2WI显示,基底动脉瘤样扩张,并由内膜瓣分隔为真腔(呈低信号)和假腔(呈混杂高信号,箭头所示) 1c 图1b同一层面TOF-MRA显示,真腔内血流呈高信号,假腔后部"弯月"样壁间血肿呈高信号(箭头所示) 1d 横断面抑脂黑血T_1WI显示,真腔呈低信号,假腔内不同时期血栓和壁间血肿呈"洋葱皮"样改变(箭头所示) 1e 矢状位抑脂黑血T_1WI可见桥前池巨大肿物,并由内膜瓣分隔为不同信号强度的真腔(箭头所示)和假腔

Figure 1 A 41-year-old male patient had suffered from barylalia and choking during drinking water for one month before he was hospitalized, and was considered as intracranial dissecting aneurysm. Lateral DSA showed fusiform enlargement of distal portion of right vertebral artery and basilar artery, as well as slight stenosis at proximal basilar artery (arrow indicates, Panel 1a). Axial T_2WI revealed basilar artery ectasia which contained true lumen (low signal) and false lumen (heterogeneous high signal) separated by intimal flap (arrow indicates, Panel 1b). TOF-MRA at the same slice as Panel 1b showed hyperintense true lumen and "crescent" hyperintense intramural hematoma located in the rear of false lumen (arrow indicates, Panel 1c). Axial fat suppression T_1WI black blood sequence showed hypointense true lumen and "onionskin" appearance composed of thrombosis of different stages and intramural hematoma in false lumen (arrow indicates, Panel 1d). Sagittal fat suppression T_1WI black blood sequence revealed giant mass in prepontile cistern, and true and false lumens with different intensities divided by intimal flap (arrow indicates, Panel 1e).

颅内动脉夹层外壁向外突起形成瘤样扩张,称为颅内夹层动脉瘤。临床表现为头痛、缺血性或出血性症状,体积较大者压迫邻近脑组织或脑神经而引起相应症状。影像学须同时关注管腔和管壁两方面变化,MRI是重要诊断手段,其他常用方法还包括DSA、CTA和MRA等。DSA可以动态观察颅内夹层动脉瘤的血流方式和管腔构型,典型征象包括"串珠征",即动脉瘤腔不规则或梭形扩张伴或不伴瘤腔近端和(或)远端狭窄;"双腔征",即不规则狭窄和(或)迂曲扩张的管腔(图1a),静脉期可见假腔内对比剂滞留。其局限性是,颅内夹层动脉瘤伴壁间血肿形成或瘤腔内部分血栓形成时无法显示病变全貌;管径正常时易漏诊;管腔狭窄或闭塞时不易与动脉粥样硬化、动脉炎等相鉴别。MRI特别是高分辨力血管壁成像可以同时提供管腔和管壁信息,弥补DSA、CTA和MRA不足,不仅能够直接显示内膜瓣、真腔和(或)假腔、壁间血肿和假腔内机化血栓(图1b~1e),还能够根据动脉外壁不规则"囊袋"样扩张而明确诊断。延长扩张型和巨大占位型颅内夹层动脉瘤好发于椎-基底动脉,前者病变沿长轴累及基底动脉全长,管腔扩张迂曲,管壁内膜下多发夹层样改变,假腔内广泛血栓形成;后者壁间血肿巨大,不同时期血肿层次混杂,呈"洋葱皮"样改变,占位效应明显,邻近脑组织明显受压变形(图1d,1e),管腔可狭窄、扩张(图1a)或正常。

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