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个案与短篇

经皮颈动脉闭塞后再通并支架置入1例

唐思治,罗霄鹏,熊 峰,唐兰英 (412000 湖南 株洲,株洲市一医院神经内科)

[**关键词**] 颈动脉闭塞;再通;支架置入
[**中图法分类号**] R543.405 [**文献标志码**] B

颈内动脉颅外段粥样硬化闭塞性病变是缺血性卒中的重要病因之一,其所致脑梗死受多种因素影响,如狭窄程度和侧支循环等[1]。我科近期完成颈内动脉闭塞再通支架置入术1例,现报告如下。

1 临床资料

患者,男性,62岁,因"头晕、左侧肢体麻木、乏力10 d"于2011年2月23日急诊入院。患者下车时突发头晕,左侧肢体麻木、乏力,持续数秒钟后好转,在外院头颅CT检查未见异常,患者后来间发左侧肢体无力,来我院以"脑梗死"收治我科。否认"高血压、糖尿病、心脏病"。查体:生命体征平稳,心肺无异常发现。神经系统检查:意识清楚,精神欠佳,言语清楚流利,左侧鼻唇沟轻度变浅,伸舌居中;四肢肌力肌张力正常,左侧肢体痛觉轻度减退(与右侧相比约减少40%),病理反射未引出,NIHSS评分:2分。颈部血管彩超检查:双侧颈动脉硬化并粥样斑块形成,右侧颈内动脉入口处斑块堵塞并血流量减少。头颅MRI:右侧额顶叶多灶性脑梗死。入院5 d后行DSA检查,结果发现:右侧颈内动脉完全闭塞(图1),右侧后交通动脉代偿右侧大脑中动脉,左侧颈内动脉造影未见前交通动脉开放。经与家属谈话并签写手术同意术,于3月6日予患者行右侧颈内动脉闭塞后再通并支架植入术。

8F导引导管置于右侧颈总动脉远端近颈内动脉闭塞处,微导丝在微导管支撑下,快速转动微导丝,钻通右侧颈内动脉闭塞处,将微导管送达颈内动脉远端,退出微导丝,微导管造影见右侧大脑中动脉显影良好,将0.010交换导丝通过微导管送到右侧颈内动脉虹吸部,予EV3(Protégé 1 mm×1.5 mm)球囊沿交换导丝送到狭窄处在11个大气压下预扩,满意后予EV3(Protégé 2.5 mm×1.5 mm)球囊沿交换导丝送到狭窄处在12个大气压下预扩,满意后做路径图,在路径图指导下,通过快速交换,将EV3 6F保护伞送达右侧颈内动脉狭窄段远端约10 cm处,退出交换导丝,予自彭式EV3[(6~8) mm×40 mm]支架沿保护伞导丝送到狭窄处,释放支架,造影见狭窄解除,支架远端仍有局限性狭窄约60%。将自彭式EV3(Protégé 6 mm×30 mm)支架送到原支架远端并部分重叠,释放支架,造影见支架贴壁良好,狭窄解除(图2),退下保护伞,造影见颈内动脉远端充盈良好,右侧大脑中动脉显影良好,手术结束。

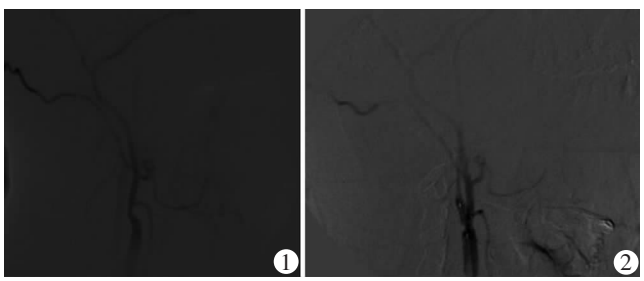


图1 右侧颈内动脉造影示右侧颈内动脉闭塞
图2 钻通闭塞处后支架植入血管造影 见狭窄解除

[**通信作者**] 罗霄鹏,E-mail:ZZLXP0525@sina.com

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术后患者精神情况明显好转,6 h后拔除动脉鞘,予低分子肝素4 100 IU,皮下注射,2/d,维持1周;氯吡格雷75 mg,每日1次口服,阿司匹林100 mg,每日口服1次。术后第2天,患者能自由下床活动,未再发左侧肢体乏力,NIHSS评分:0分。术后第3天带药出院,术后7 d TCD示右侧大脑中动脉血流情况正常,颈部血管彩超示支架贴壁良好。

2 讨论

在缺血性脑卒中众多危险因素中,脑动脉狭窄或闭塞是缺血性卒中的独立危险因素,手术干预性治疗已有40年历史。本例患者右侧颈内动脉入口处闭塞后,右侧前循环血流通过右侧后交通动脉部分代偿,但后交通动脉无法保证充分的前循环的供血,致患者表现为右侧颈内动脉TIA表现。且由于长期低灌注最终导致右侧额顶叶多灶性脑梗死(动脉远端供血区)。

根据陆清声[2]报道,约40%的颈内动脉完全闭塞者其远端流出道仍存在,其原因可能为颅底动脉环的侧支循环有血液反流入颈内动脉所致。本病例术中见右侧后交通动脉代偿右侧大脑中动脉,再次验证了近端完全闭塞远端流出道仍存在的情况。虽然从1958年开始就不断有关于闭塞颈动脉血运重建的个案报道,但颅内动脉闭塞临床治疗困难。内科抗凝、抗血小板治疗常不能控制卒中发作;外科颅内-颅外血管吻合术常受多种因素的限制,且临床研究中外科治疗组患者预后显著差于药物治疗组[3],故该方法目前基本被放弃;近年来,颈内动脉内支架成形术(CAS)的应用逐渐增多,CAS与CEA的对照研究也正在进行之中[4]。CAS可减轻颅内血管狭窄程度,提高缺血区血流供应,理论上说能降低后继卒中发生风险。

以往观点认为,颈内动脉闭塞程度达100%的患者,由于导丝无法通过完全闭塞部位[5],无法用支架成形术进行治疗。本例患者术中通过微导丝在微导管支撑下,快速转动微导丝,钻通右侧颈内动脉闭塞处,在闭塞处形成一条通道,为CAS手术顺利进行打下基础。虽然对于颈内动脉完全闭塞的治疗临床上尚未取得统一的结论,但是我们认为对于颈内动脉闭塞的患者由有经验的神经介入医师完成CAS还是可以获益的。

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