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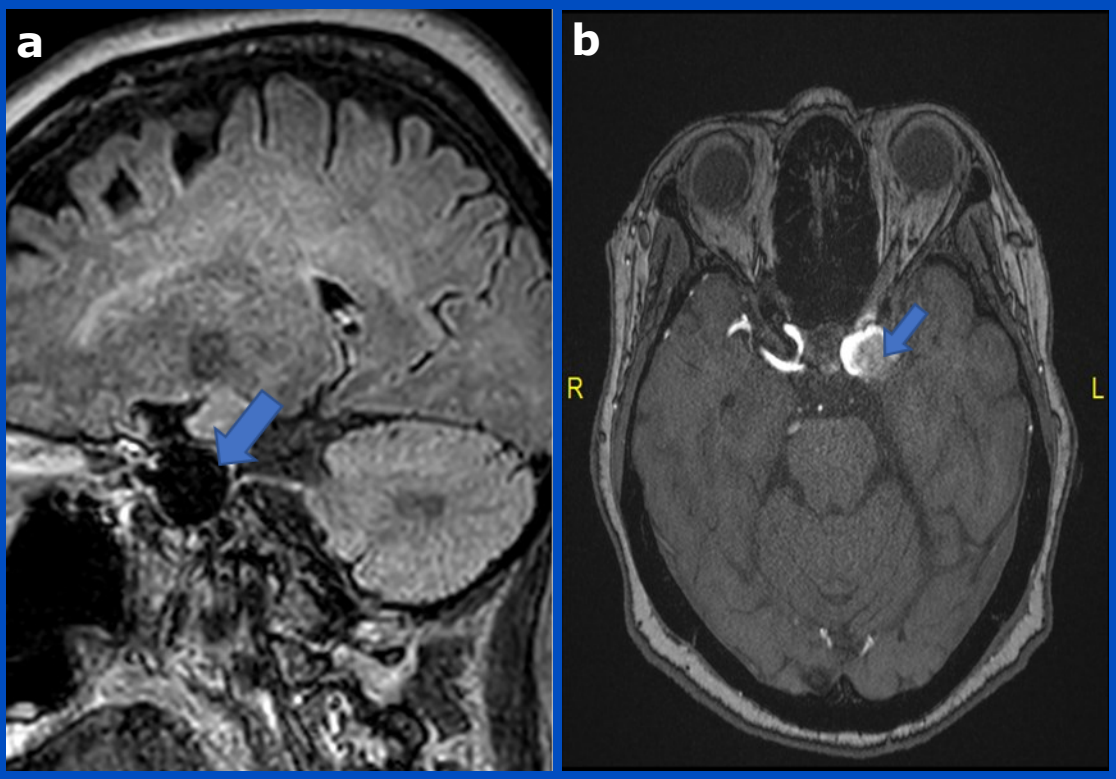

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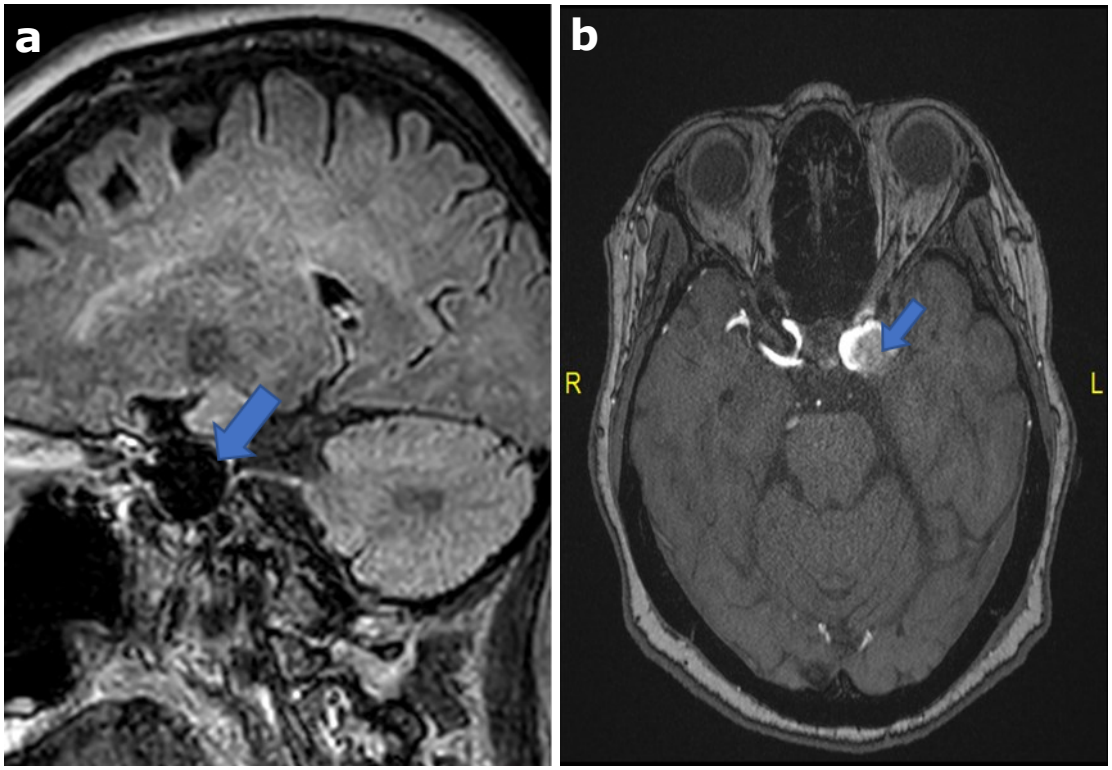

Figure 1

73-year-old lady presented with pulsatile pain over the left side of the face for the past 2 years, which was worsening for the past 1 month. The pain involve the whole left side of the face, however it was not associated with numbness of facial muscle weakness. Power of all limbs were normal. No weakness. Magnetic Resonance Imaging (MRI) Fluid Attenuated Inversion Recovery (FLAIR) showed hypointense lesion at the region of the left cavernous sinus measuring 1.7cm x 2.8cm, occupying the left Meckel's cave, indicated with arrow in figure 1a. In MRI Time of Flight (TOF) sequence, the lesion demonstrated high signal intensity as indicated with arrow in Figure 1b.

What is the diagnosis?

***Answer**: refer to page 127*

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DISCLOSURE: There is no conflict of interest and consent has been obtained from patient for use of these images.

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(Refer to page 126)

ANSWER: LEFT INTERNAL CAROTID ARTERY (ICA) CAVERNOUS SEGMENT FUSIFORM ANEURYSM CAUSING LEFT TRIGEMINAL NERVE COMPRESSION RESULTING IN LEFT TRIGEMINAL NEURALGIA.

The patient underwent a left carotid angiogram which confirmed the diagnosis of a left carotid artery aneurysm (Figure 2). The pulsatile nature of the carotid artery aneurysm and its close proximity to the left trigeminal nerve and ganglia was the cause of the patient's left facial pulsatile pain.

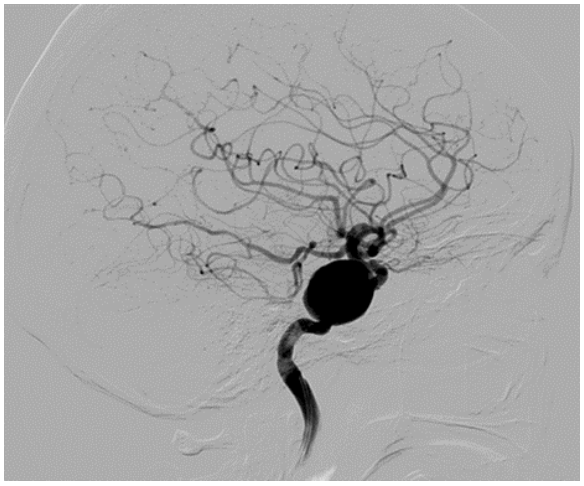

Figure 2: Left Internal Carotid Artery (ICA) Conventional Angiogram showed fusiform dilatation of the left ICA measuring 1.7cm x 2.8cm.

Giant carotid aneurysm occurrence is about 3% to 5 % of all intracranial aneurysm.[1] Depending on the location of the aneurysm, it can cause cranial nerve palsy. In this particular case, the aneurysm is located at the left Meckel's cave which host the left trigeminal nerve. Due to pulsatile nature of the aneurysm, it causes pulsatile pain to the patient. It is important that the lesion does not mistakenly diagnosed as tumour or mass, as it may lead to different direction of treatment and management of patient. Magnetic Resonance Angiogram (MRA) TOF can shows arterialization of the lesion while diagnostic catheter angiogram is confirmatory gold standard test.

Option of treatment includes endovascular coiling of the aneurysm or therapeutic sacrifice of the ICA. With proper patient selection for each option, both options of endovascular treatment were proven to give good result.[2] She was planned for endovascular therapy (stenting and coiling) of the left ICA aneurysm, unfortunately we did not manage to cannulate the distal part of aneurysm. Another option is to go for therapeutic left ICA occlusion however patient opted for conservative management for now and is under regular follow up

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2: WJ van Rooij and M Sluzewski. Unruptured Large and Giant Carotid Artery Aneurysms Presenting with Cranial Nerve Palsy: Comparison of Clinical Recovery after Selective Aneurysm Coiling and Therapeutic Carotid Artery Occlusion. Am J Neuroradiol. 2008;29(5):997-1002. DOI: https://doi.org/10.3174/ajnr.A1023 [Accessed at 1st July 2020].