Flow Diversion for Ophthalmic Artery Aneurysms


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ABSTRACT

SUMMARY: Endovascular treatments of ophthalmic segment aneurysms are commonly used but visual outcomes remain a concern. We performed a retrospective review of patients with carotid-ophthalmic aneurysms treated with flow diversion from June 2009 to June 2015. The following outcomes were studied through chart review: visual outcomes, complications, postoperative stroke and intraparenchymal hemorrhage, and clinical outcomes. Angiographic outcomes were studied with angiography and MRA at 6 months, 1 year, and 3 years. We evaluated 50 carotid-ophthalmic aneurysms in 48 patients, among whom 44 patients with 46 aneurysms underwent treatment. The mean clinical follow-up was 29 ± 22 months (range, 0–65 months). There were no permanent adverse visual outcomes. There was 1 death because of late intraparenchymal hemorrhage (2.2%). Six-month angiography showed complete occlusion in 24 of 37 patients (64.9%), and 3-year angiography results showed occlusion in 24 of 25 patients (96%). In conclusion, flow diversion is a safe and effective treatment for carotid-ophthalmic aneurysms in carefully selected patients. The risk of adverse visual outcomes is low, and most aneurysms progress to complete occlusion.

ABBREVIATION: PED = Pipeline Embolization Device

Flow-diverting stents work by directing blood flow away from the aneurysm into the parent vessel, leading to stasis of blood flow within the aneurysm, thrombosis, and, ultimately, complete exclusion of the aneurysm from circulation via endothelial proliferation along the struts of the device. Initial preclinical studies suggested that branch vessels covered by the device remain patent because the flow gradient at the branch vessel takeoff inhibits endothelial proliferation. In practice, flow diverters have been shown to lead to aneurysm occlusion rates ranging from 69%–94% at 6 months, increasing to 86.8%–95% at 1 year. These initial series also reported a wide range of postprocedure morbidity and mortality up to 19%. Recently, several series have been published on the specific treatment of paraclinoid aneurysms with the Pipeline Embolization Device (PED; Covidien, Irvine, California) and Surpass Device (Stryker Neurovascular, Kalamazoo, Michigan), reporting complete or near-complete occlusion rates of 75%–92.1% at final angiographic follow-up with very low rates of postprocedure morbidity. Many of these series were relatively small, with short angiographic follow-up, and included vastly diverse aneurysms with a common denominator of involvement of the paraclinoid ICA. In this study, we reported on a large series of patients with carotid-ophthalmic artery aneurysms, focusing on periprocedural complications as well as mid- and long-term angiographic and clinical outcomes, including visual outcomes.

MATERIALS AND METHODS

Patient Population

Consecutive prospectively collected data on 175 patients evaluated for treatment with PED or, more recently, with Surpass flow diversion were retrospectively analyzed. Patients with carotid-ophthalmic artery aneurysms were identified and analyzed. Carotid-ophthalmic aneurysms were identified and analyzed. Carotid-ophthalmic aneurysms were defined as those aneurysms arising from the proximal supraclinoid ICA at the takeoff of the ophthalmic artery with a superior orientation of the aneurysm sac. Information prospectively collected as part of an internal quality assurance project included patient demographics; aneurysm location, classification, and size; symptomatic or asymptomatic status; type and number of devices used; adjunctive coil ing; periprocedural technical and clinical complications; length of hospital stay; and angiographic and clinical follow-up.

Procedure Details

Patients undergoing placement of the PED were premedicated with aspirin and clopidogrel for a minimum of 5 days, and the device was placed while the patient was under full anticoagulation.
similar to the operative technique for placement of the PED.

Recurrence after previous non–stent-assisted coiling in patients were treated for mirror aneurysms. The mean patient age was 4 years, and 41 aneurysms (93%) were found in women.

Among the 46 aneurysms, 37 (80.4%) had 6-month angiographic follow-up, which showed complete occlusion in 24 (64.9%) and persistent filling in 13 (35.1%) based on strict angiographic criteria. Exclusion from 6-month angiography was found for the following reasons: death (1 patient), and refusal (2 patients). Six patients have not had angiographic follow-up due to the fact that they were less than 6 months out from the procedure at the time of this study. At 1 year, 29 of these 37 aneurysms (78.4%) were completely occluded and 8 (21.6%) showed persistent filling. At 3-year follow-up, 24 of 25 aneurysms (96%) were occluded (Figure). No aneurysms shown to be occluded were found to have recanalized on later angiography. Among patients with angiographic follow-up, the ophthalmic artery was patent in 29 (78.4%). Among the 8 patients in whom ophthalmic artery occlusion was noted, all had reconstitution of the ophthalmic artery through collaterals. In 7 patients, this occurred through external carotid artery collaterals, and in 1 patient, it occurred through the inferolateral trunk.

The mean clinical follow-up was 29 ± 22 months (range, 0–65) and no patient was lost to clinical follow-up. At 12 days, 1 patient with a 21-mm aneurysm died of a delayed distal intraparenchymal hemorrhage not related to aneurysm rupture (procedure related mortality, 2.2%), and 3 patients died of newly diagnosed (after the treatment) metastatic cancer at a mean of 40.7 months (range, 31–53 months). There were no delayed aneurysm ruptures. At 3 months, 1 patient experienced transient peripheral vision loss, possibly related to ipsilateral embolism from the device based upon MRI, which showed several small foci of restricted diffusion. She did not experience permanent vision loss. At 3 and 6 months after PED placement, 2 patients experienced possible amaurosis fugax that resolved after reestablishing dual antiplatelet therapy. The ophthalmic artery remained patent in all these patients. No other ophthalmologic complications were noted, and aside from the patient who suffered distal intraparenchymal hemorrhage, no other patient suffered a permanent neurologic deterioration because of the immediate or delayed effect of the procedure.

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subgroup analysis of the Pipeline for Uncoilable or Failed Aneu-
rysms (PUFS) trial, Salhein et al15 examined the neuro-ophthal-
mologic outcomes of 98 patients with ICA aneurysms who had
neuro-ophthalmologic follow-up. Of the 30 paraophthalmic seg-
ment aneurysms treated in this study, 8 presented with visual field
or cranial nerve deficits, and 7 patients reported improvement in
symptoms with treatment. There were no cases of worsening of
visual field or cranial nerve deficits among paraophthalmic aneu-
rysms in this study. Similar results have been reported in other
large series of paraophthalmic aneurysms receiving flow-diverter
treatment.11,13 Likewise, in our series of 44 patients with 46 aneu-
rysms, no patients experienced visual worsening after flow-di-
verter treatment. A recent international retrospective review of
aneurysms treated with flow diversion revealed that complica-
tions were more likely in aneurysms larger than 10 mm and
among those in the posterior circulation.16 The lone death in our
series occurred in a patient with a 21-mm aneurysm.

In general, complete or near-complete occlusion rates after
flow-diverter treatment are on the order of 90% and rates of neu-
rologic complications are low. In our series of 46 ophthalmic seg-
ment aneurysms, we saw a progressive increase in the rate of com-
plete occlusion over time, starting with an occlusion rate of 64.9% at
6 months that increased to 96% at 3 years. There was only 1
death related to the procedure.6

Similar to prior studies, we found very few instances of oph-
thalmic artery occlusion after placement of a flow diverter across
the ophthalmic artery ostium. In a series of 95 patients in which
the ophthalmic artery was covered by at least 1 flow diverter,
Chalouhi et al17 found that the ophthalmic artery remained pat-
ent in nearly 95% of patients. Puffer et al18 found that the oph-
thalmic artery was patent in over 80% of patients after placement
of a PED across its ostium. In our study, the ophthalmic artery was
occluded in 21.6% of patients, and in no patient did this result in
any new visual symptoms. Ophthalmic artery occlusion after
placement of flow diverters across the origin of the artery is more
likely to occur if patients have robust collaterals. In patients with
inadequate collaterals, the ophthalmic artery stays open akin to
important perforating vessels covered by these devices. In such
cases, the pressure gradient across the artery (present because of
the lack of important collaterals) maintains the patency of the
vessel. Because occlusion of the ophthalmic artery occurs almost
exclusively in patients with adequate collaterals, patients do not
experience symptoms related to occlusion.

Other treatment options for ophthalmic segment aneurysms
include microsurgical clipping and coiling with or without stent
assistance. Complex ophthalmic segment aneurysms can be
treated microsurgically with acceptable rates of complete occlu-
sion (53%), but the complexity of the surgical procedure may put
the patient at risk of worsened visual symptoms postoperatively (with up to 21% of patients with preoperative visual symptoms having postoperative worsening in some series). Conventional endovascular coiling for ophthalmic segment aneurysms carries low risk based on published series (1.4% morbidity, 0% mortality), but 12% of patients treated via conventional endovascular coiling required retreatment.\(^{20,21}\)

**Limitations**

Our study is limited by the retrospective nature of the review, despite the prospectively maintained data base. The data base used for this study included patients treated with flow diversion over several years, and procedural techniques as well as aneurysm morphology deemed amenable to flow diversion have likely changed over that time. It is unclear what effect these changes would have on the analysis, but this still should be noted. Visual field testing was not performed in all patients, and thus, true deficits may be underrepresented. Finally, the 1 patient treated with the Surpass device precludes flow-divertter comparison. Despite these limitations, our series provides a contemporary snapshot of results for a specific subset of aneurysms (true carotid-ophthalmic aneurysms) in an institution where flow diversion has been considered the treatment of choice since its inception.

**CONCLUSIONS**

Endovascular flow diversion is a viable treatment option for ophthalmic segment aneurysms, resulting in a high rate of complete or near-complete occlusion and a low rate of complications (specifically, no permanent visual field deficits). Further studies examining neuro-opthalmologic outcomes after flow-divertter treatment of paraophthalmic aneurysms would be helpful to confirm these findings.


**REFERENCES**