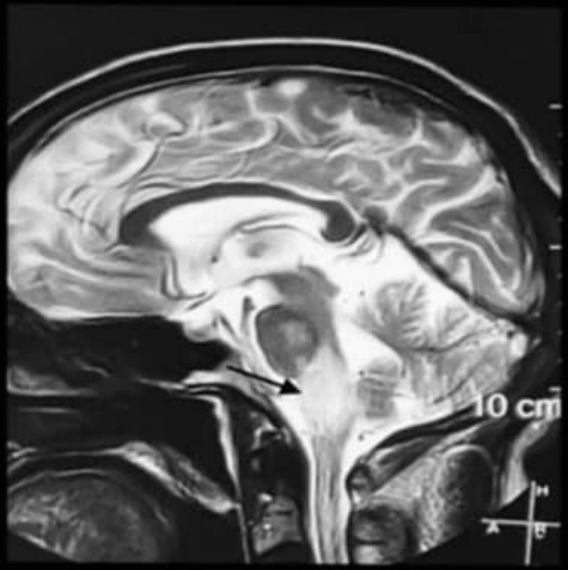
DAVFs- We Should Not Miss A Treatable Disorder

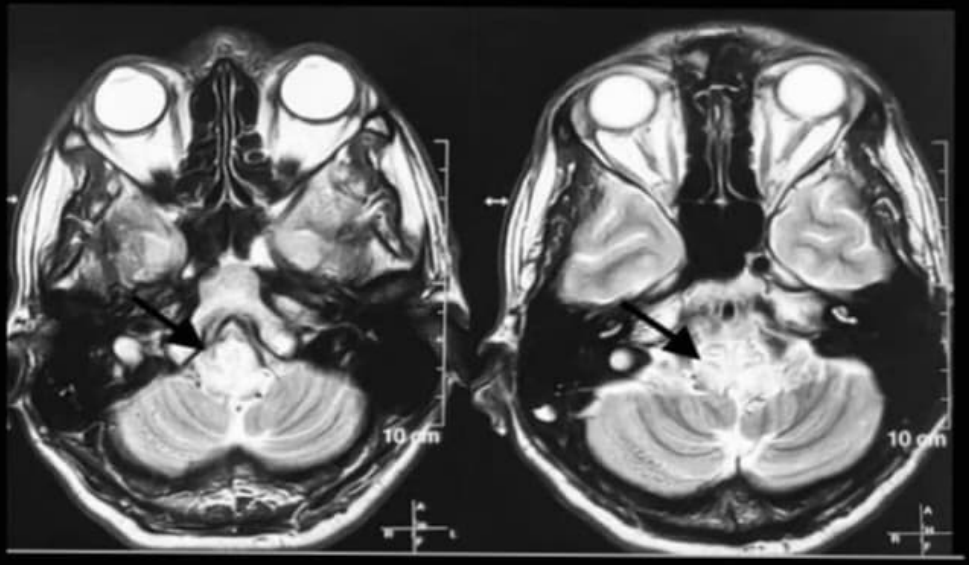
RS/ 62 yrs

3 months history of Progressively worsening unsteady gait, dysarthria, dysphagia

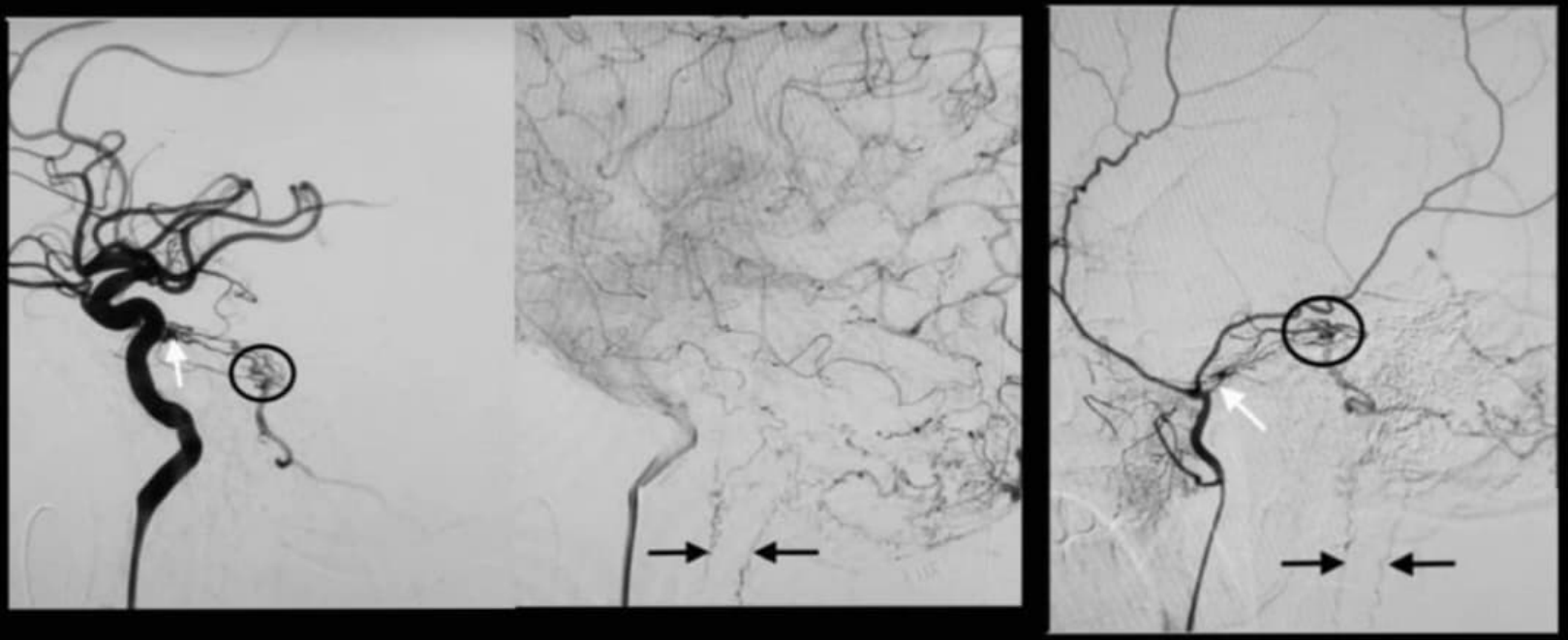
Rapid worsening, intubation on admission (E1VtM2)



Diffuse hyper signal with
internal linear signals

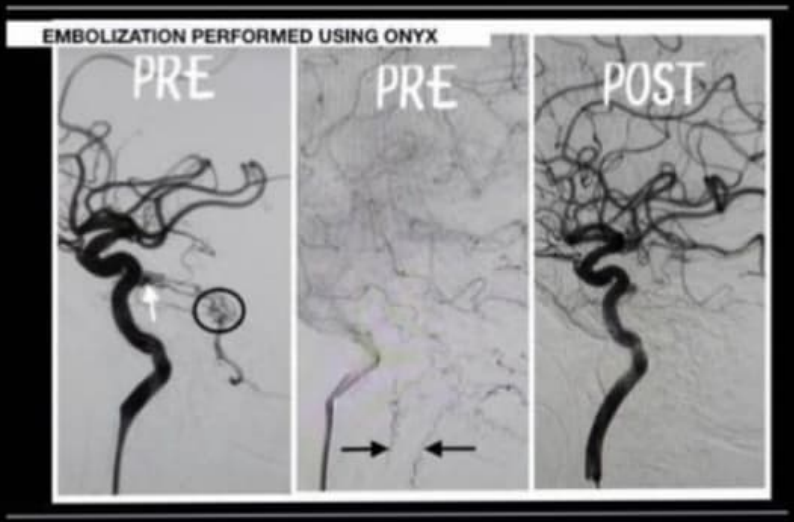


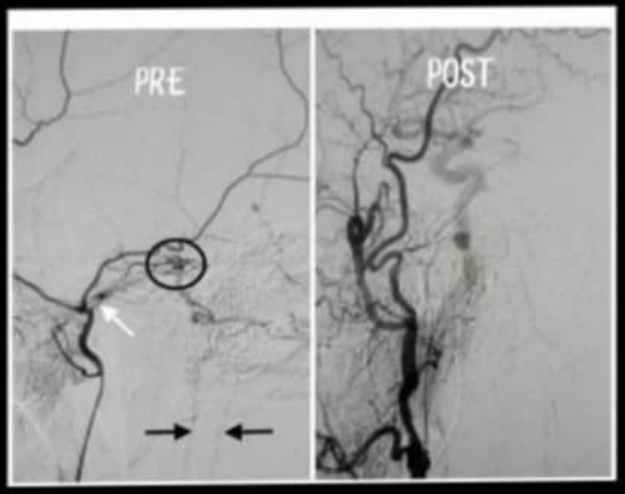
Central medulla edema suspicious
of venous congestion, ischemia

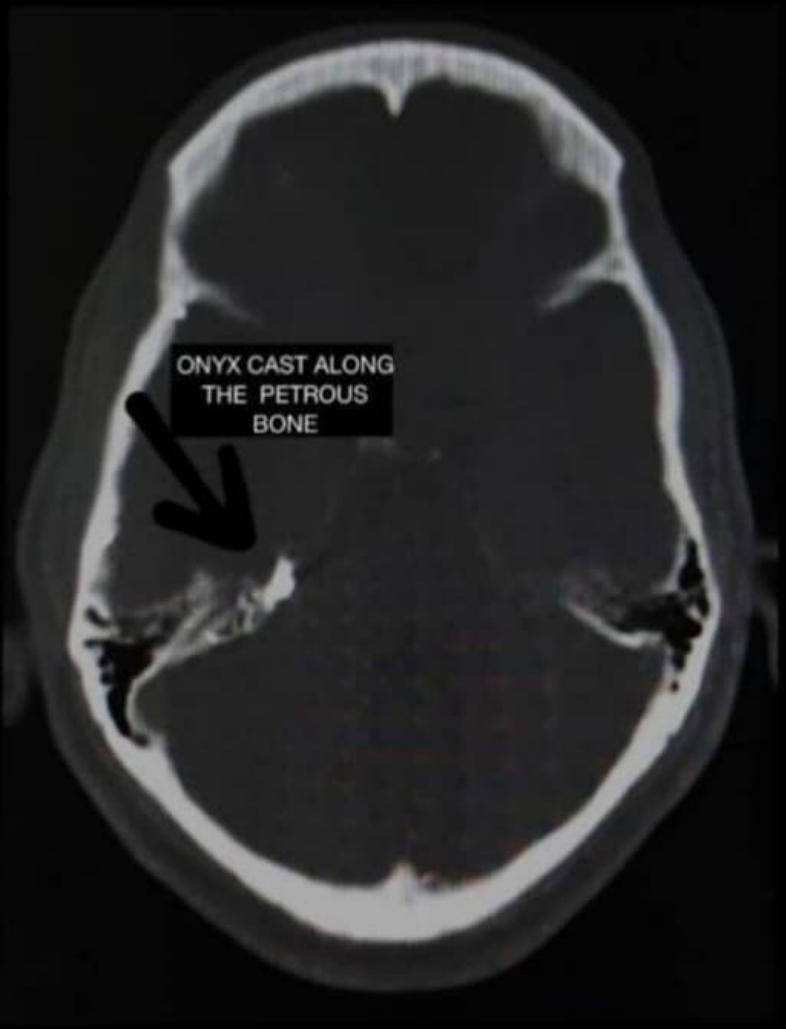


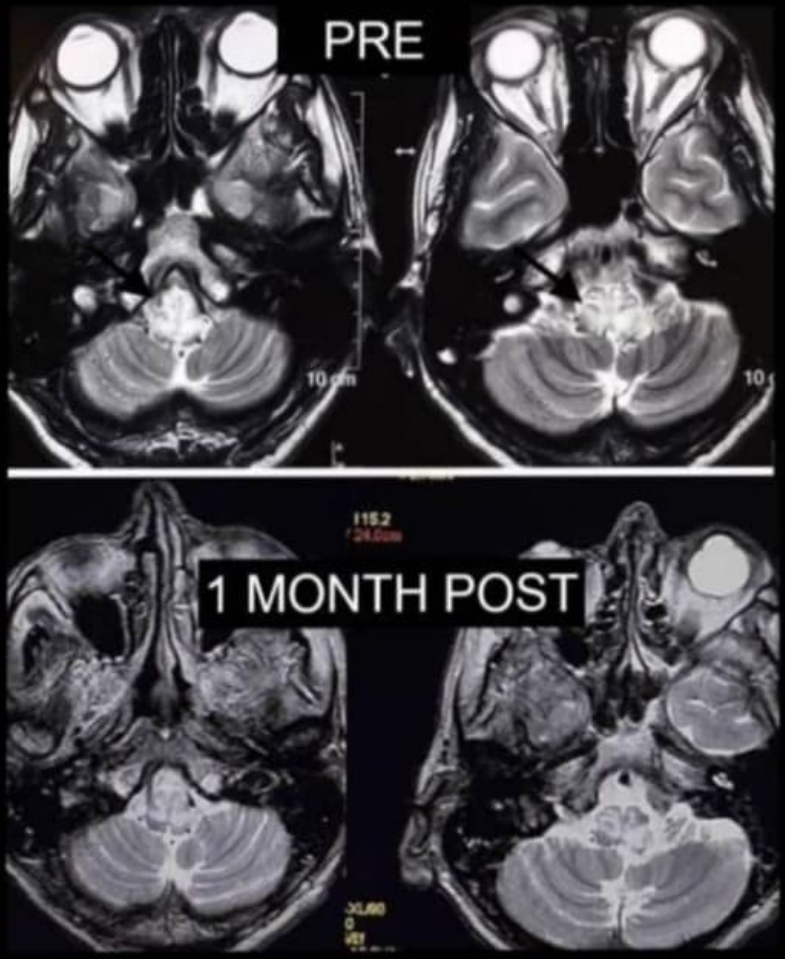
Petrosal DAVF congesting the Petrosal V causing venous hypertension in clival, perimedullary and spinal vv

Selective embolization led to angiographic cure

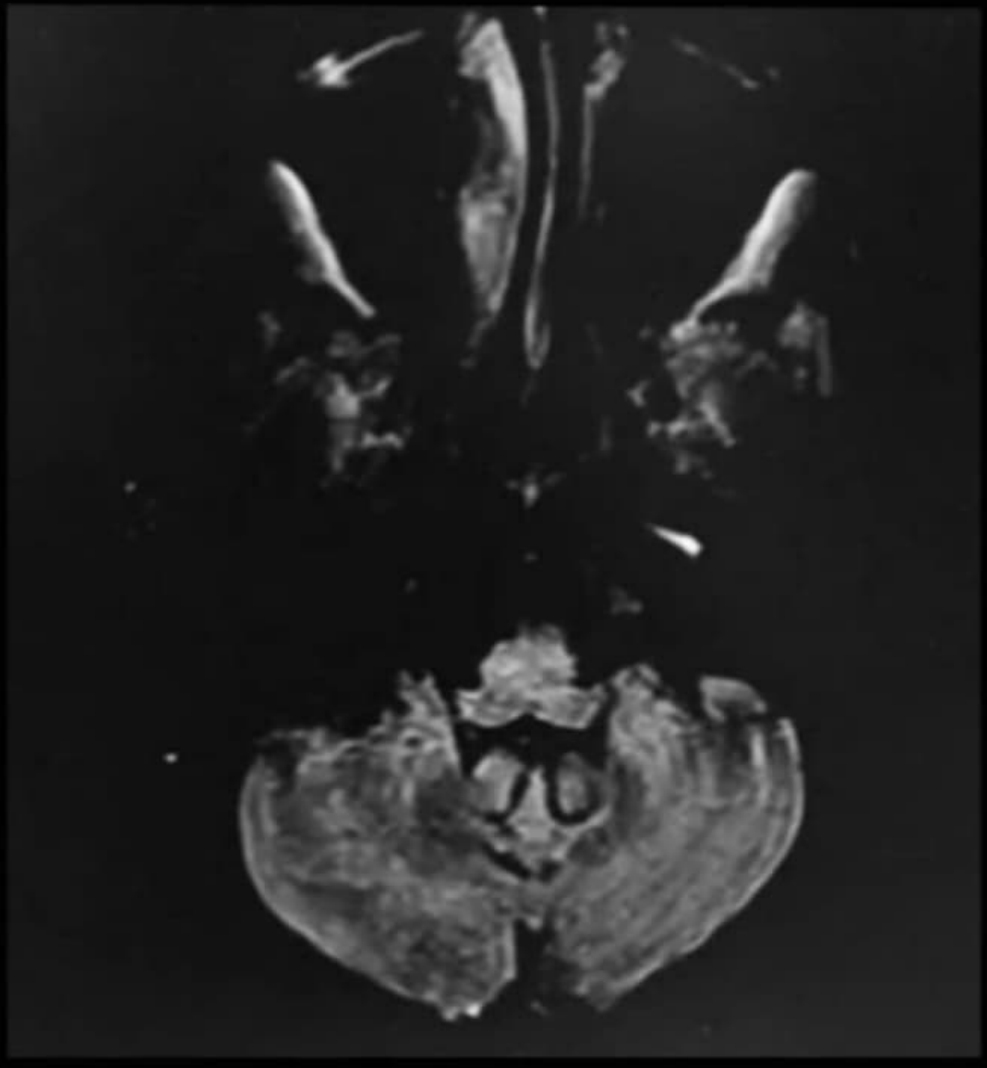




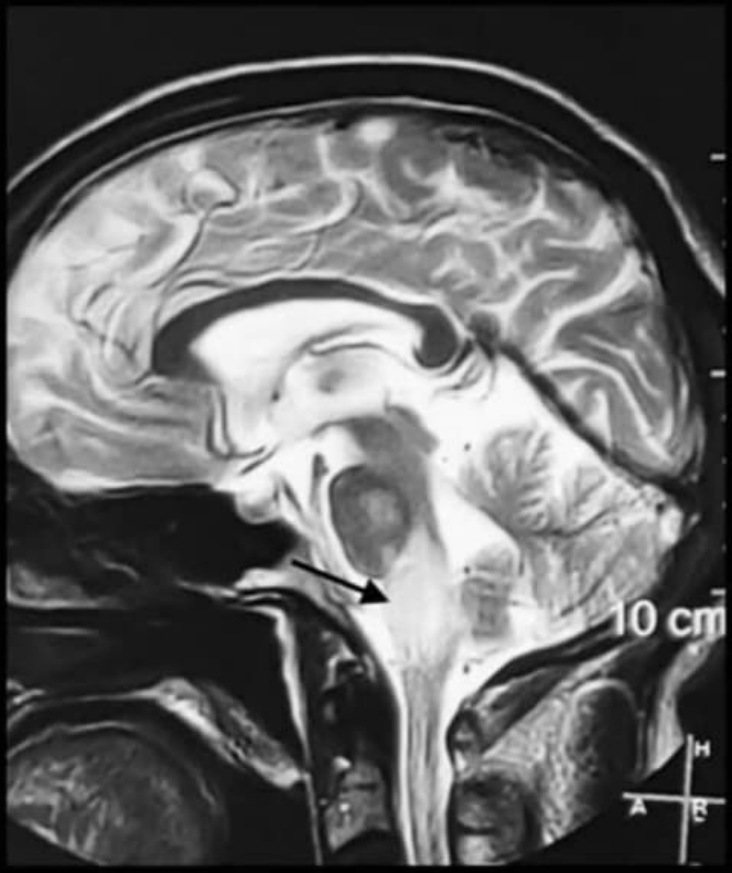

ONYX CAST ALONG
THE PETROUS
BONE


PRE
1 MONTH POST

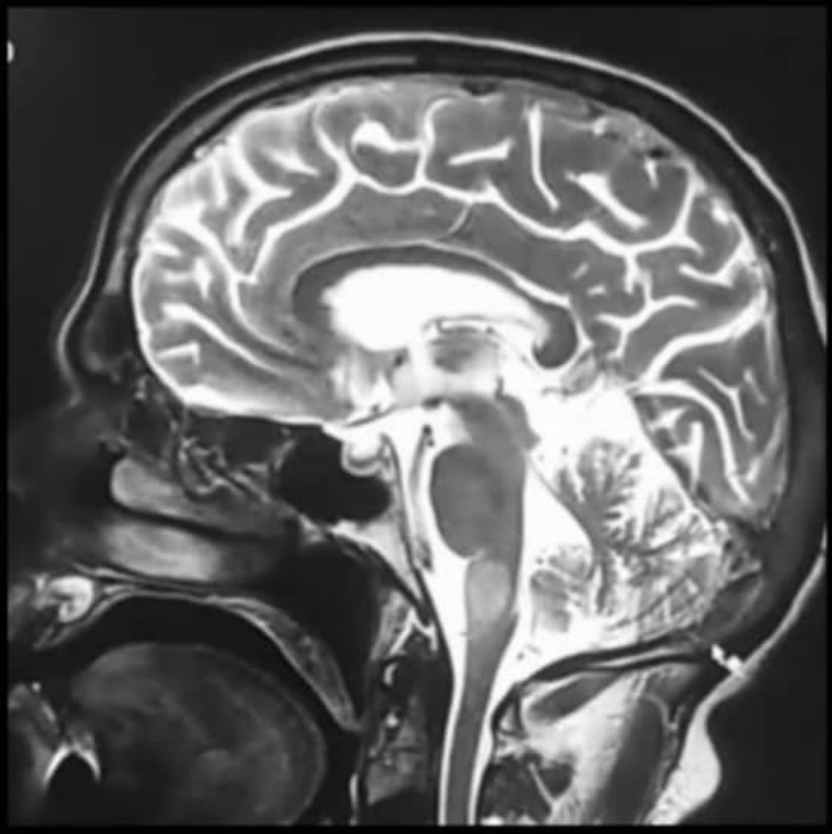
Remarkable improvement over a week. Had LMN facial which significantly recovered in a month



Conscious oriented Walking without support
No difficulty in swallowing. Speech normal in 6 weeks



PRE



POST

Unusual but charaterstic pattern of medullary edema with areas of sparing should prompt scrutiny for atypical perimedullary vessels.

DSA should be recommended.

Pattern contrasts with infiltrative process seen in brain tumors.

Goal of treatment is closure of draining vein proximally as it exits the fistula

Cranial DAVFs not uncommonly give mild nonspecific symptoms which can rapidly change to an acute / life threatening CVA.

Prompt diagnosis & aggressive intervention leads to rapid resolution of venous congestion and resultant clinical recovery.

Case courtesy- Nishant Bhargava, Raipur