

Predictors for the Durability of Endovascular Treatment for Intracranial Aneurysms

Nitin Agarwal BS; Akram Shhadeh; Ennis J. Duffis M.D.; Steven Hoover MD; Charles J. Prestigiacomo MD FACS; Wenzhuan He MD, MS; Chirag D. Gandhi MD

Department of Neurological Surgery, Rutgers New Jersey Medical School, Newark, New Jersey, United States of America

RUTGERS New Jersey Medical Schoo

Introduction

Endovascular coil embolization has become increasingly utilized for the treatment of intracranial aneurysms. Still, controversy exists regarding the long-term durability of this technique. The objective of this study is to assess the effect of aneurysm configuration on the durability of coil embolization.

Methods

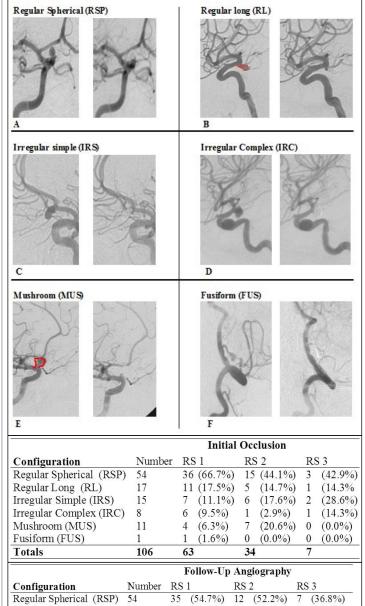
Retrospective analysis of all patients treated by coil embolization from August 2002 through September 2008 who underwent follow up angiography at least 3 weeks after embolization. Demographic data and aneurysm characteristics, including configuration, were recorded. Two endovascular specialists assessed aneurysm occlusion on initial and followup angiography, and graded using the Raymond Scale (RS). The influence of patient data and aneurysm configuration on the initial obliteration and occurrence of recanalization were examined.

Results

The most frequent aneurysm configuration was the regular spherical (RSP), while the least common was fusiform. There were no differences in the distribution of aneurysm configuration with regard to age and sex. Based on the initial occlusion, RSP configuration was found to have the highest RS 1 rates (66.7%). Mushroom configurations were found to have the lowest rates (0%). Aneurysms that were initially RS 1 were more stable at follow-up than those in which only RS 2 or RS 3 occlusion could be achieved. As such, the initial RS did seem to influence durability. RSP aneurysms were most common and largely were unchanged on follow-up.

Conclusions

Aneurysm configuration is an interesting factor for future studies exploring the natural history of endovascular treatment of aneurysms and developing more durable endovascular techniques.



Fotals	106	64		23		19	
Fusiform (FUS)	1	1	(1.6%)	0	(0.0%)	10.00	(0.0%)
Mushroom (MUS)	11	2	(7.8%)	1	(4.3%)		(26.3%)
		5	· /	1			· · ·
rregular Complex (IRC)	8	6	(9.4%)	1	(4.3%)	1	(5.3%)
rregular Simple (IRS)	15	7	(10.9%)	4	(17.4%)	4	(21.1%)
Regular Long (RL)	17	10	(15.6%)	5	(21.7%)	2	(10.5%)
Regular Spherical (RSP)	54	35	(54.7%)	12	(52.2%)	7	(36.8%)

References

1.Bederson JB, Awad IA, Wiebers DO, Piepgras D, Haley EC, Jr., Brott T, Hademenos G, Chyatte D, Rosenwasser R, Caroselli C: Recommendations for the management of patients with unruptured intracranial aneurysms: A statement for healthcare professionals from the stroke council of the american heart association. Stroke; a journal of cerebral circulation 31:2742-2750, 2000.

2.Molyneux A, Kerr R, Stratton I, Sandercock P, Clarke M, Shrimpton J, Holman R: International subarachnoid aneurysm trial (isat) of neurosurgical clipping versus endovascular coiling in 2143 patients with ruptured intracranial aneurysms: A randomised trial. Lancet 360:1267-1274, 2002.

3.Raymond J, Guilbert F, Weill A, Georganos SA, Juravsky L, Lambert A, Lamoureux J, Chagnon M, Roy D: Long-term angiographic recurrences after selective endovascular treatment of aneurysms with detachable coils. Stroke; a journal of cerebral circulation 34:1398-1403, 2003.

4.Thornton J, Debrun GM, Aletich VA, Bashir Q, Charbel FT, Ausman J: Follow-up angiography of intracranial aneurysms treated with endovascular placement of guglielmi detachable coils. Neurosurgery 50:239-249; discussion 249-250, 2002.

5.Xavier AR, Abdelbaky A, Rayes M, Tiwari A, Narayanan S: Clinical and angiographic outcome in patients with completely occluded intracranial aneurysms by endovascular coiling: Our experience. Journal of neurointerventional surgery, 2011.

