LETTER / Cardiovascular imaging

Clinical presentation and percutaneous endovascular management of acute left subclavian artery thrombosis: Report of two cases

Keywords: Left acute upper extremity ischemia; Thrombosis; Endovascular

Acute subclavian artery thrombosis is a rare cause of upper extremity or cerebral ischemia. Diagnosis and origin must be rapidly established, to allow an appropriate management in order to prevent catastrophic vertebral-basilar stroke. Surgery is often complex and inappropriate in emergency. Angioplasty and stenting are widespread used, in the management of subclavian artery stenosis [1–3]. Stenting an acute subclavian artery thrombosis is technically feasible, in intention to trap thrombus underlies. However, protection to vertebral-basilar embolism or treatment is a remaining successful key-point of endovascular management. Herein, we report two cases of acute subclavian thrombosis treated by percutaneous endovascular stenting of a culprit lesion, while technique to treat (1st case) or to prevent vertebral-basilar embolism (2nd case) were deployed.

Case No. 1

This is a 43-year-old woman referred in emergency by her general practitioner to our department. Since 2 hours after awakening, she presents an acute left arm pain associated to nausea. Clinical examination shows an acute left upper extremity ischemia associated with abnormal neurologic examination. Soon after her admission, she developed left hemiplegia, dysphagia and fell into a deep coma. On the immediately performed non-contrast enhance cerebral computed tomography (CT) scanner no abnormality was observed. A chest and neck CT angiography (CTA) revealed a left subclavian artery extensive thrombosis of the two proximal centimeters (Fig. 1a). Because of patient clinical status, deep and fast deterioration, an endovascular management was proposed in emergency. The global aortic arch angiography showed a proximal subclavian artery occlusion. By a right selective vertebral angiography, a basilar trunk embolic occlusion was found. This occlusion was on centimeter above the postero-inferior cerebellar artery takeoff (Fig. 1b). Basilar trunk was super-selectively catheterized with a 3 Fr microcatheter (Renegade® HI-FLO™ Boston Scientific Natick, MA US), through the right vertebral artery by the right humeral artery. The microcatheter was positioned above the postero-inferior cerebellar artery takeoff, and then a local fibrinolysis with 1 million IU of urokinase was delivered over one hour. While thrombolysis was ongoing, the left subclavian artery was catheterized by a femoral approach. A self-expandable stent (8.0 × 30 mm Wallstent® Boston Scientific Natick, MA) was deployed over the lesion to trap the thrombus between the arterial wall and the stent (Fig. 1c). One hour after fibrinolysis onset, because neither clinical status nor angiographic findings had improved; a selective thrombus aspiration was performed as it:
- the left vertebral artery was catheterized with a 8Fr 150 cm length sheath;
- a 4Fr Glide catheter (Terumo Somerset, NJ US) was advance to the thrombus head;
- and then a gentle manual aspiration with a 20 mL Medallion® (Merit Medical South Jordan UT USA) syringe was performed.

Only one single aspiration fairway was needed to aspirate the occlusive thrombus. The post-aspiration angiogram performed confirms the basilar trunk full patency (Fig. 1d). The patient had a full recovery in the following 3 hours. Electrocardiographic monitoring and transthoracic and transesophageal echocardiograms were normal. She was placed for 6 months under curative anticoagulation with vitamin K antagonist the substitute by aspirin until the last follow-up available. Five years later, the patient’s neurologic and left arm vascular statuses were normal.

Case No. 2

This is medical story of a 42-year-old woman referred for supra-aortic angiography. Forty-height before, a left arm pain, with cyanosis and paraesthesia suddenly appear. Clinical examination show:
- cold left hand with no left cubital pulse;
- normal neurological examination.

A non-fractioned heparin therapy was begun before her transfer to our department for supra-aortic angiography. One the aortic arch global angiography, nearly occlusive thrombus was observed into the left subclavian artery ostium (Fig. 2a). Because of the high risk of cerebral embolization and after a multidisciplinary discussion, an endovascular approach as a treatment was decided.
By a left humeral artery approach, a 4 × 20 mm angioplasty balloon, was inflated as a cerebral protection against thrombus migration into the left vertebral close to the ostium. Then, a 6 Fr femoral-armed 150 mm length sheath (Cook Flexor® Cook Medical Bloomington, IN 47402-4195 USA) was advanced in front of the left subclavian artery. Thrombus was crossed by a 0.035 J glide guide wire. Then two self-expandable (Absolut®, 10 0.035 × 20 ↔ mm Abbott Vascular, Abbott Park, IL) were deployed, to trap thrombus underlies. After stenting, balloon (10 0.035 × 20 ↔ mm) inflation was performed to shape correctly the two stents (Fig. 2b). During the balloon inflation, the vertebral protection balloon was deflated to wash out potential embolized thrombi, by reversal flow through the vertebral artery. The last angiogram performed shows the full patency of the subclavian and vertebral artery (Fig. 2c). No cerebral embolism was observed. An occlusion of the cubital artery, with the full patency of radial and deep palmar arch was finding on the angiography. Transthoracic and transesophageal echocardiograms showed mild left ventricular hypertrophy and 24-h electrocardiographic monitoring was normal. The patient was placed on long-term anticoagulation with a vitamin K antagonist for 6 month, substituted by aspirin. The 2 years last follow-up available demonstrate that the patient was in stable health and vascular status of her left arm was normal.

Discussion

Acute thrombosis of the subclavian arteries is a rare cause of upper limb ischemia, usually promoted by an underlying abnormality of the aortic arch, aortic arch syndrome, trauma, arterial catheter or a pre-existing atheromatous stenosis [4–10]. In the two cases presented, no prothrombotic hematologic abnormality was found. Cardiac origin of embolism could not be firmly excluded. However, both cardiac statuses were almost normal. Despite of a definitive diagnosis was not possible; an underlying localized atheromatous plaque might responsible of the two cases of acute thrombosis. Subclavian artery ostium is one of the preferential location of early atheromatous lesion [11]. Three management strategies could be proposed in such cases:

- medical therapy, using heparin, aspirin, clopidogrel, intravenous thrombolysis and glycoprotein IIb/IIIa antagonist;
- surgical procedures, including embolectomy and bypass grafts;
- percutaneous endovascular procedures.

In our first case, a life-threatening basilar trunk stroke imposed an emergent life-saving therapy. In the second case, patient was considered to have a high surgical risk because of overweight and of short neck. Medical treatment might be
an option in absence of neurologic symptoms, but we were concerned that further embolism, especially in the vertebral artery, were unpredictable.

No clear consensus has been reached in the treatment of acute arterial thrombosis. Widlus et al. have reported favorable results in 8 patients who underwent intra-arterial thrombolysis of acute upper extremity ischemia [11]. However, in all subclavian or axillary lesions, thrombolysis had to be supplemented by percutaneous transluminal angioplasty (PTA) of the underlying lesion. Furthermore, intra-arterial thrombolysis was most effective in the treatment of no-flow lesions. Seki et al. described the use in two patients of direct intra-arterial thrombolysis alone for acute subclavian and axillary thrombosis, followed by 2 or 3 days of local thrombolysis, via intra-arterial catheter used for chemotherapy [9].

Manual aspiration is a highly effective supplementary technique to thrombolysis and angioplasty in the management of occlusive thrombotic lesions. Its efficacy is limited in large vessels. Moreover manual aspiration is frequently associated with a high risk of thrombus fragmentation and distal migration. Percutaneous angioplasty alone of lesion containing fresh thrombi stenting must be waived. This approach runs the risk of downstream embolism. Direct stenting, especially with tight meshed stents, appear to be the safest technique to trap thrombi and prevent the distal thrombus migration.

The preventive or curative endovascular treatment of embolism to the distal vascular network must be achieved at the same time as the treatment of the primary lesion. Vertebro-basilar strokes can be prevented by two different techniques. First, a protecting device can be placed in the homolateral vertebral artery with a simple balloon catheter or with a dedicated cerebral embolic protection device, like those used in carotid angioplasty [12]. In our second case, to avoid any trapped thrombus, which might migrate after balloon deflation, we paid a specific attention to overcome any dead space at the left vertebral take-off. We also used, the artificial reversing flow of the upper extremity via the vertebral artery by deflating the vertebral balloon, during occlusion of the subclavian artery [13].

Figure 2. Patients No. 2, with an acute subclavian artery thrombosis: a: on the global aortic arch angiography a non-occlusive left subclavian artery thrombosis was shown (black arrow); b: shows the per-dilatation of the two self-expandable implanted stents (white arrow). Note that the protection balloon (black arrow) occluding the left vertebral artery in place. Flow in the vertebral artery was reversed when the balloon in the vertebral artery was deflated, leaving the balloon in the subclavian artery inflated; c: the final aortic arch global angiography shows the crushed thrombus between the stent and the arterial wall (black arrow). The left vertebral and internal mammary arteries are patent.
The treatments of acute vertebro-basilar strokes include:

- intravenous thrombolysis;
- intra-arterial thrombolysis;
- thrombo-embolectomy or manual aspiration;
- PTA-stenting of residual lesions [13—19].

Eckert et al. recently reported favorable results with combination of intravenous abciximab, intra-arterial thrombolysis and PTA-stenting [14]. Pfefferkorn et al. described the use of intravenous thrombolysis combined with mechanical thrombo-embolectomy in occluded basilar artery [20]. The basilar artery was correctly reperfused in 15 of 16 patients. Seven patients had a good recovery (Rankin score ≤ 2). However, this study is limited by the absence of group control. Comparing treatment outcomes in acute vertebro-basilar stroke is challenging because of the low disease incidence and the short therapeutic window [21]. Randomized studies are complex to perform and the dismal prognosis in absence of vertebro-basilar recalibration raises ethical issue when the management of patients is limited by constraints imposed by a study protocol. Currently it is appropriate to implement all means of vertebro-basilar blood flow restoration in order to save life and prevent the development of a locked-in syndrome [22]. From a technical point of view, we use a 4 Fr glide catheter for clot aspiration. The 4 Fr glide catheter offer a large lumen, which is suitable for aspiration. However this catheter could be substitute by dedicated by clot removal device. The MERCURY retrieval system (Concentric Medical, Hertogenbosch The Netherlands) in acute ischemic stroke provide a basilar truck patency in 89.5%, associate or no to local thrombolysis [23,24].

These two cases illustrated endovascular techniques for the management of acute subclavian artery thrombosis, and preventive and curative techniques for vertebro-basilar embolism. Direct stenting is safe effective and minimize the risk of subclavian thrombus migration. The homolateral vertebral artery must be protected, whenever possible.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

References


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