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Images in vascular medicine

Bilateral common carotid artery aneurysms

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Panel A

Panel B

Panel C

Panel D

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Tracheal deviation was incidentally discovered on a chest X-ray of a 40-year-old man (Panel A). He had no focal complaints and the examination of his neck was unremarkable. However, a CT-scan revealed aneurysmal dilation of the proximal portion of both common carotid arteries (CCA) compressing the trachea (Panel B; R CCA/ L CCA, right/left common carotid artery) and a right-sided aortic arch. Both CCA had partial calcification, intraluminal thrombi, and an hourglass morphology.

The maximal diameters of the left and right side were 2.3 and 3.0 cm, respectively. Serology for syphilis, blood cultures, and antibody titers ruled out an infectious etiology. An angiogram demonstrated that both CCA were originating independently from a right-sided aorta. The takeoff of the left CCA appeared diffusely aneurysmal (Panels C and D), while multiple dilations were noted along the course of both vessels. The anomalous anatomy was completed by the stump of an aberrant occluded left subclavian artery (L SCA) and the origin of the right subclavian artery (R SCA) and right vertebral artery (R VA) from a common right brachiocephalic trunk (R BCA) coming off the ascending aorta (AA). Based on the diffusely aneurysmal takeoff of both CCA, an open surgical repair was performed. A 16 × 8-mm bifurcated PTFE graft was sewn in end-to-side fashion to the ascending aorta, tunneled underneath the clavicles, and sutured in end-to-end fashion to each CCA. The patient recovered well and was discharged on postoperative day 5. He remains well at

6 months follow-up. Extracranial aneurysms of the carotid artery are uncommon and mostly located at the CCA bifurcation.^{1,2} Owing to the risk of expansion, rupture, and thromboembolism, prompt resection is advised.³

References

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