CASE STUDY

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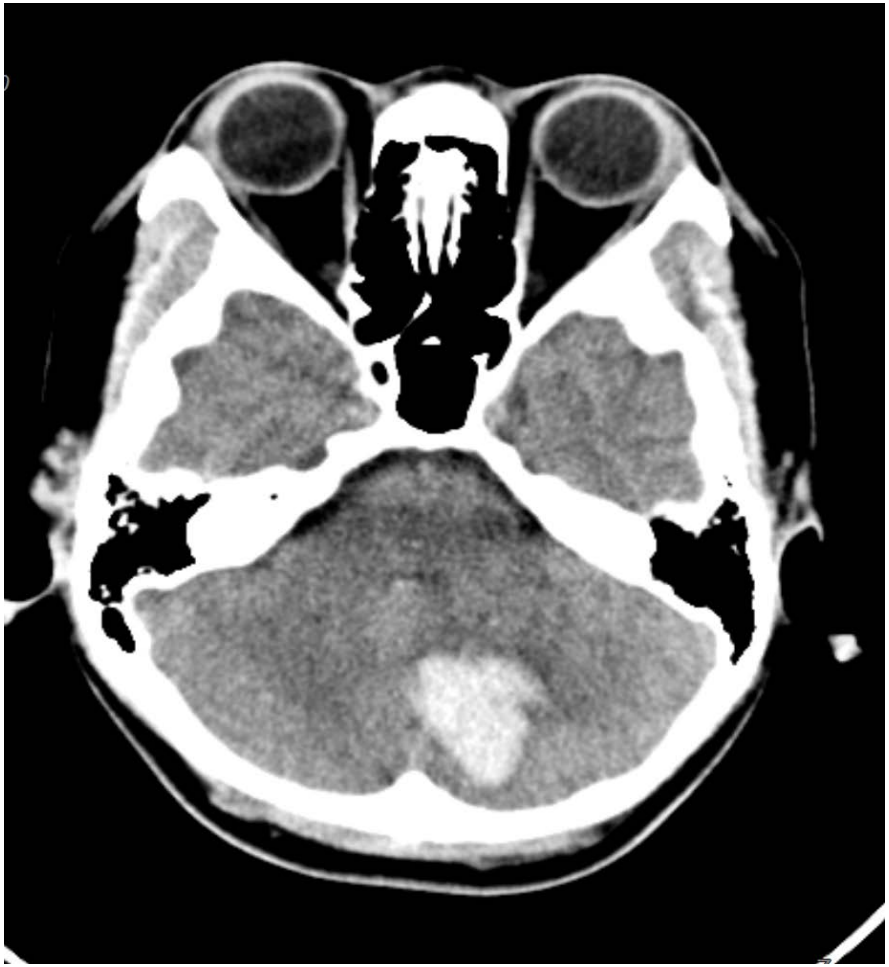
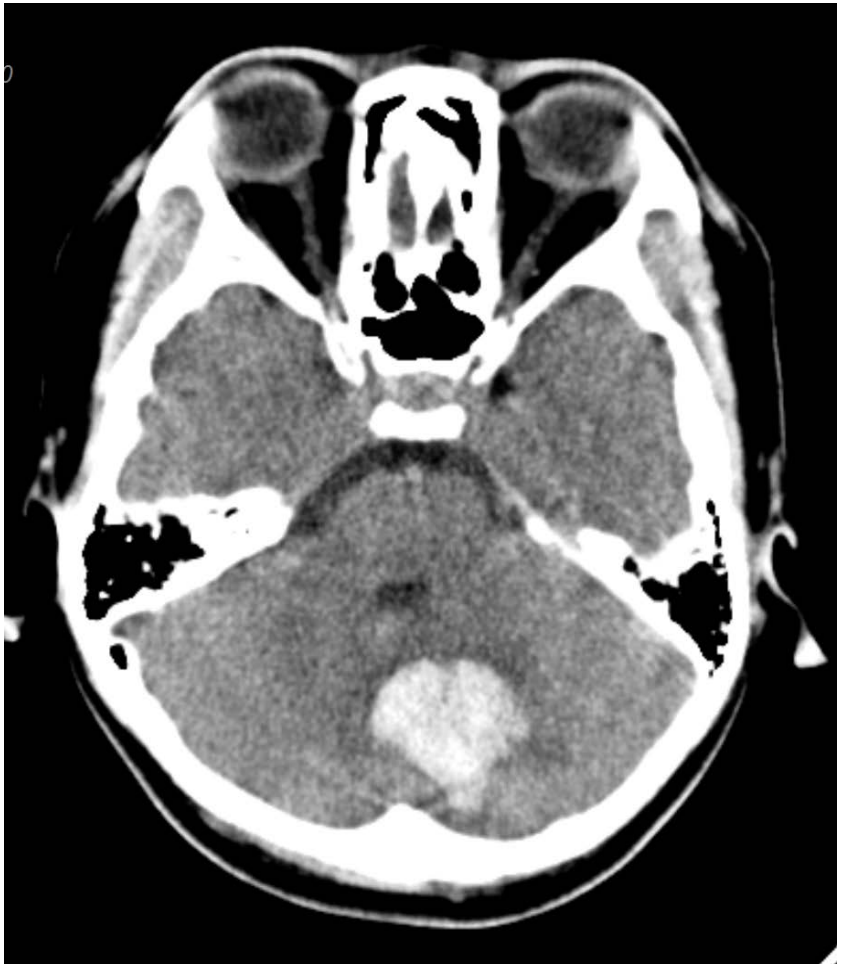
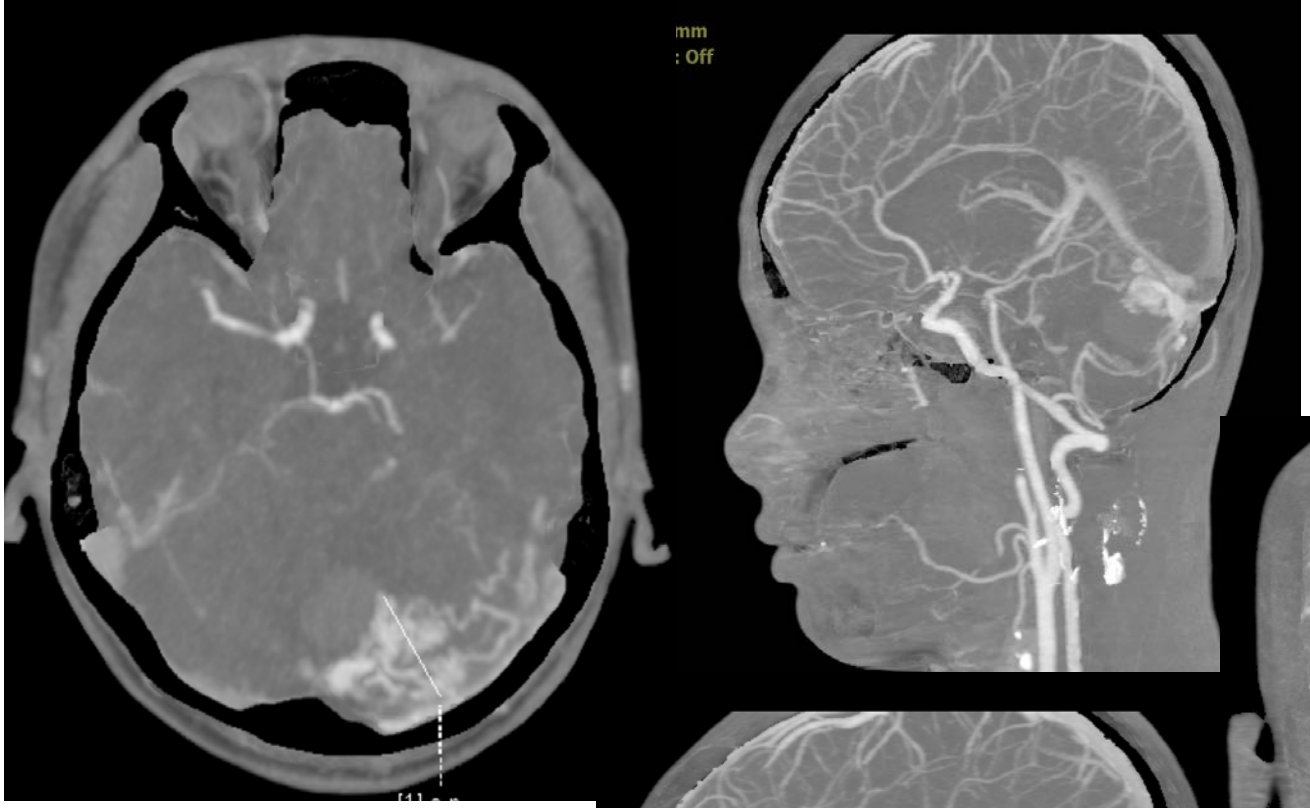
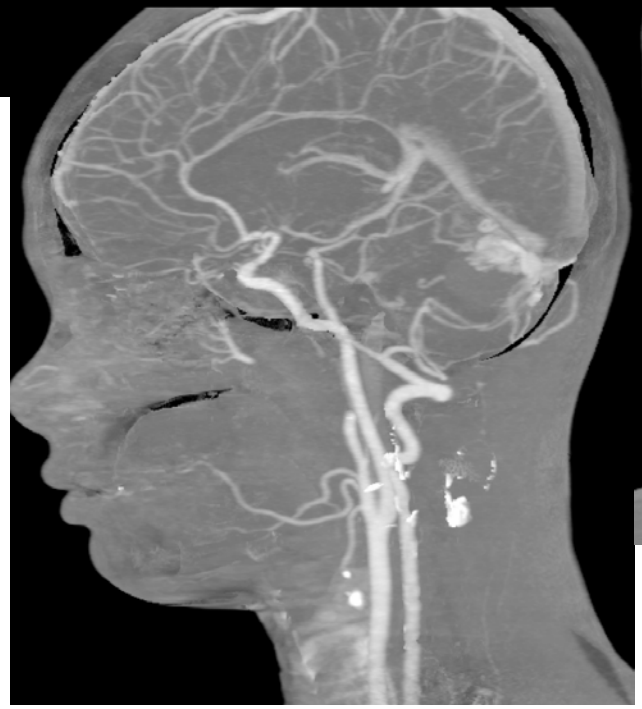
Case No1

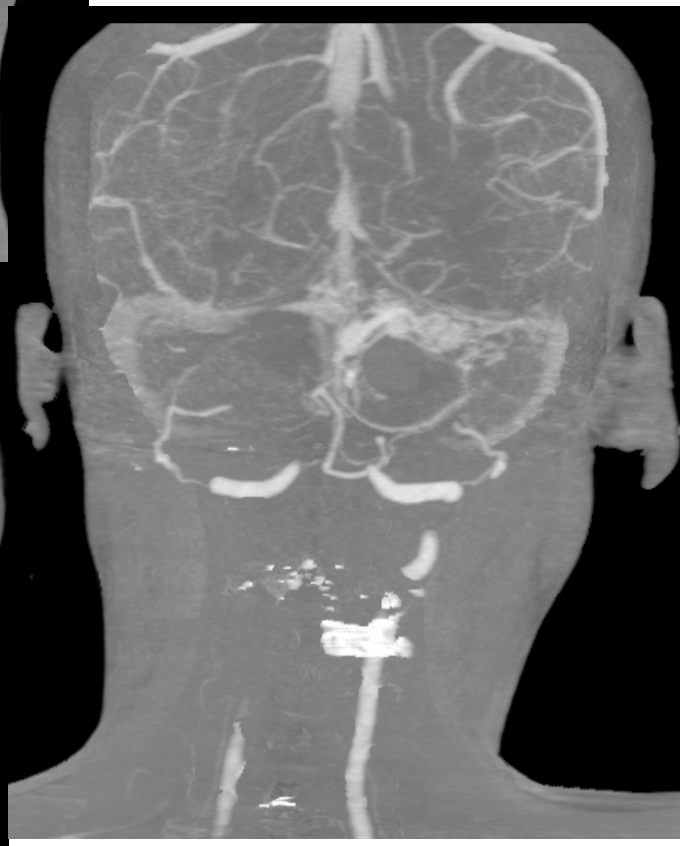
F, 16 YO, cerebellar hematoma











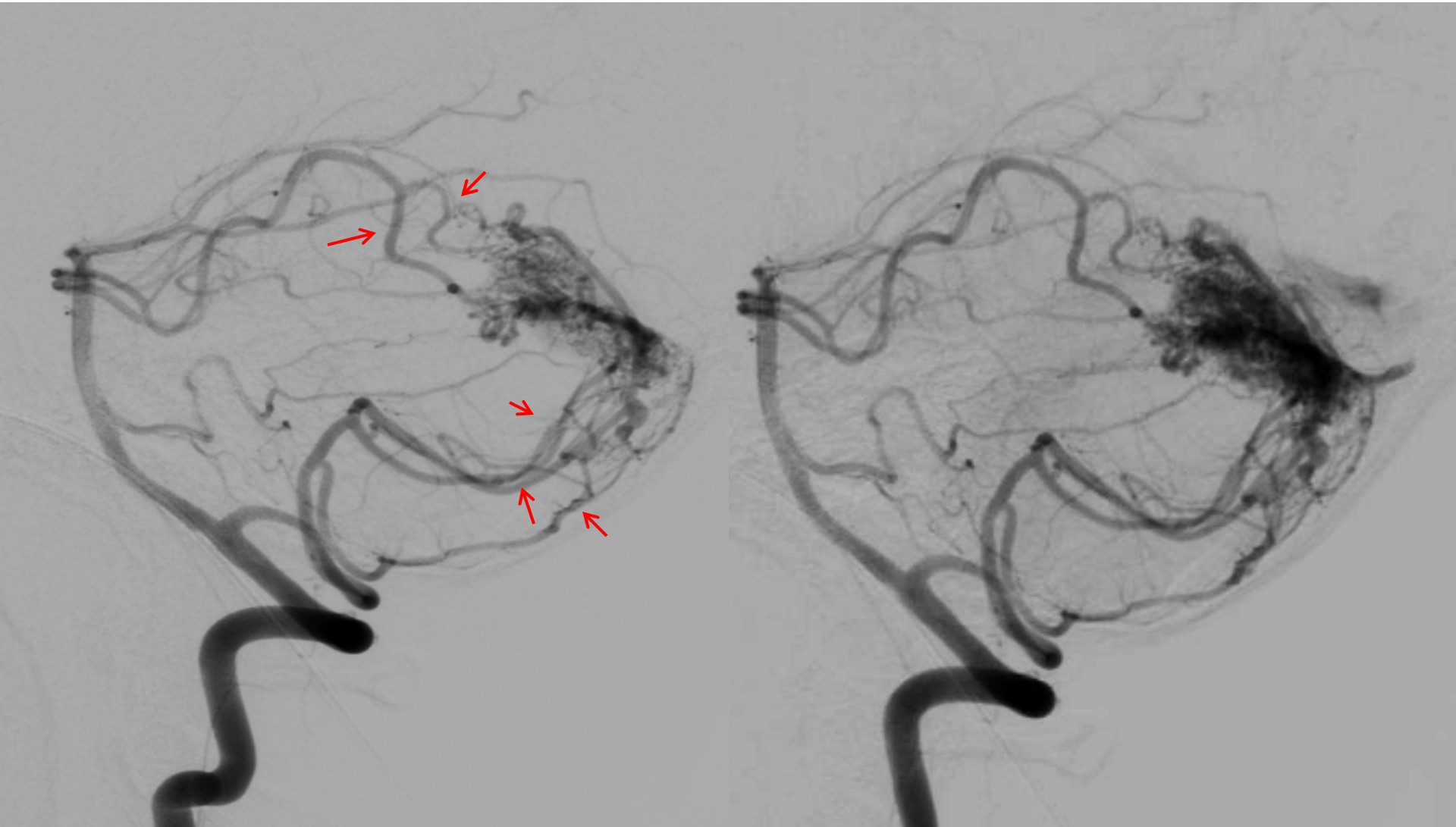
MSCT

Planing:

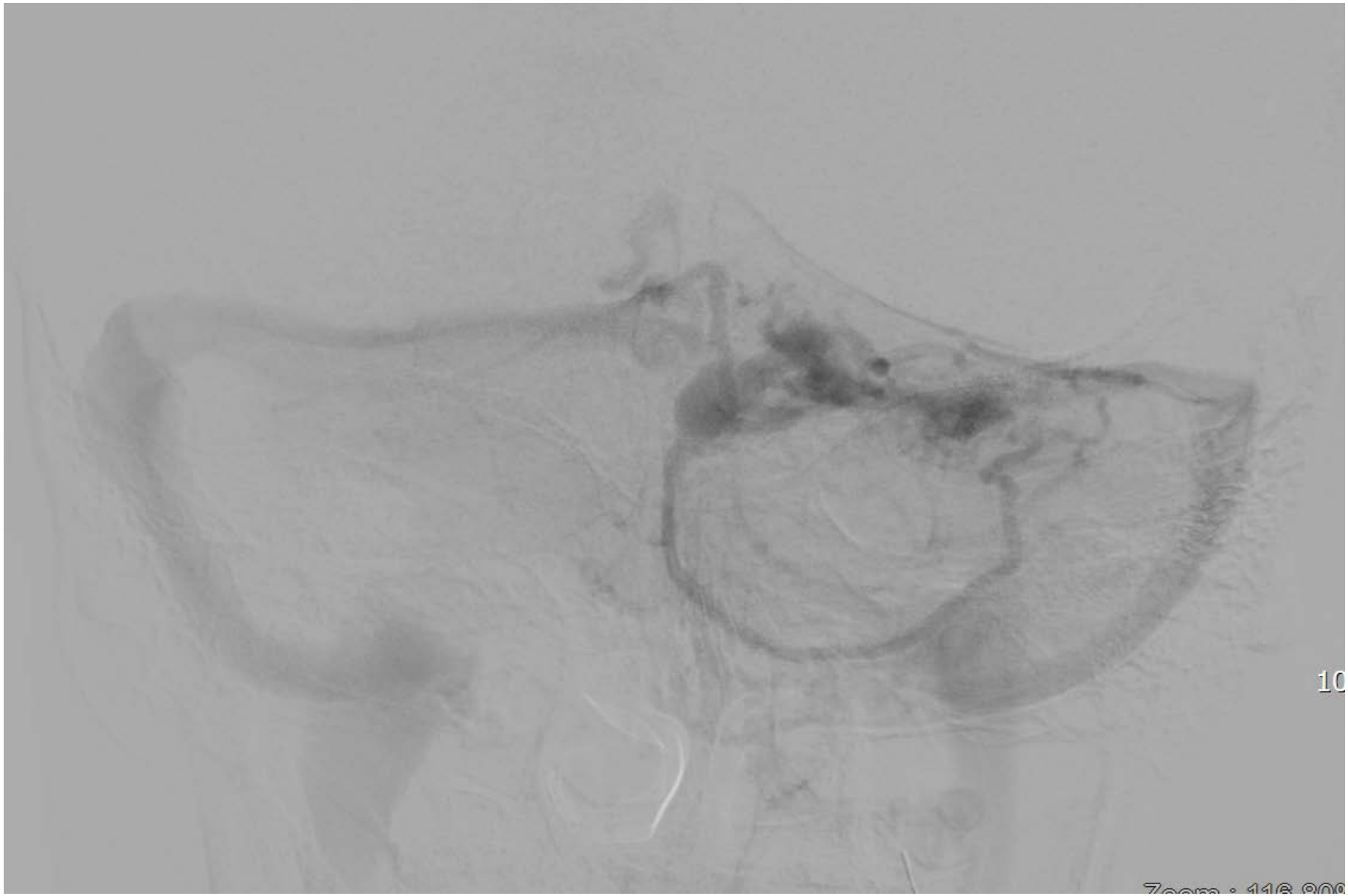
- Surgery
- Embolization
- Gamma Knife
- Partial embolization Presurgery

Partial embolization Presurgery

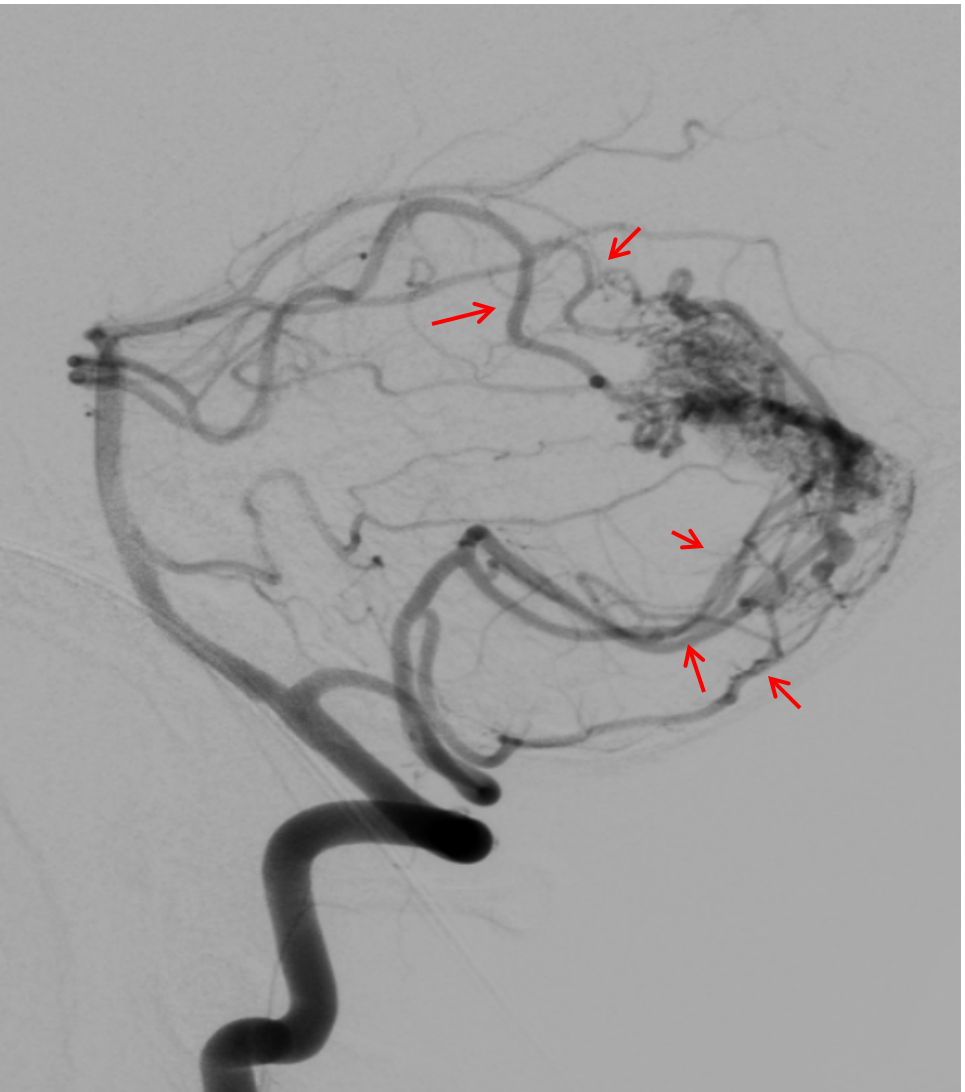
DSA: 5 feeders from SCA and PICA



Drainage veins



DSA: 5 feeders from SCA and PICA

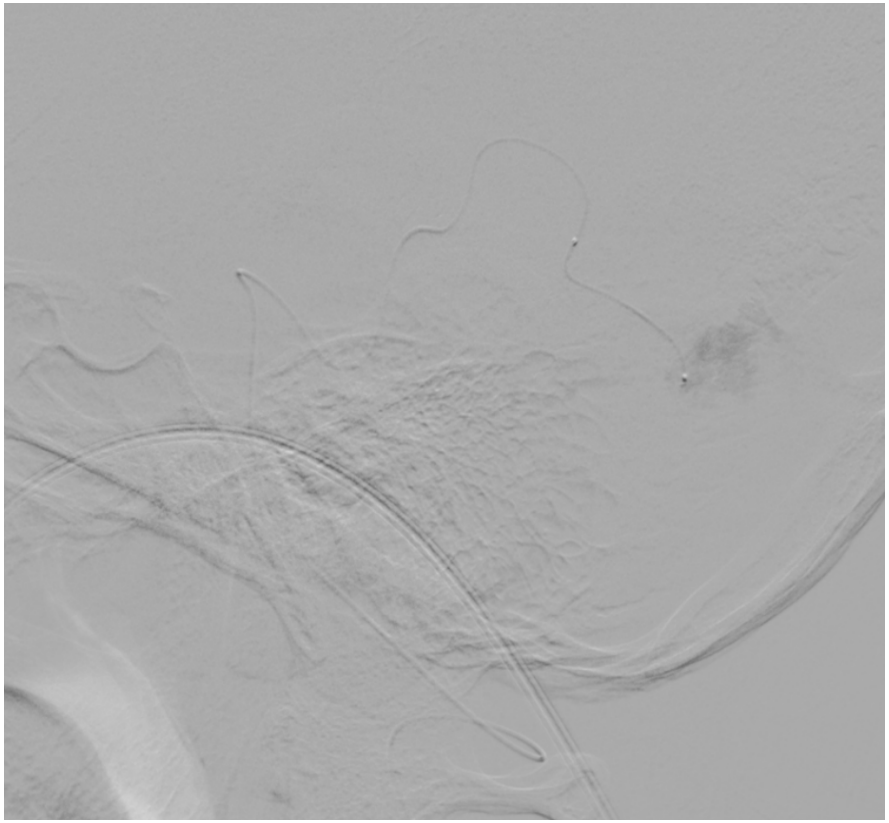


- SCA: 2 feeders, deeper
- PICA:

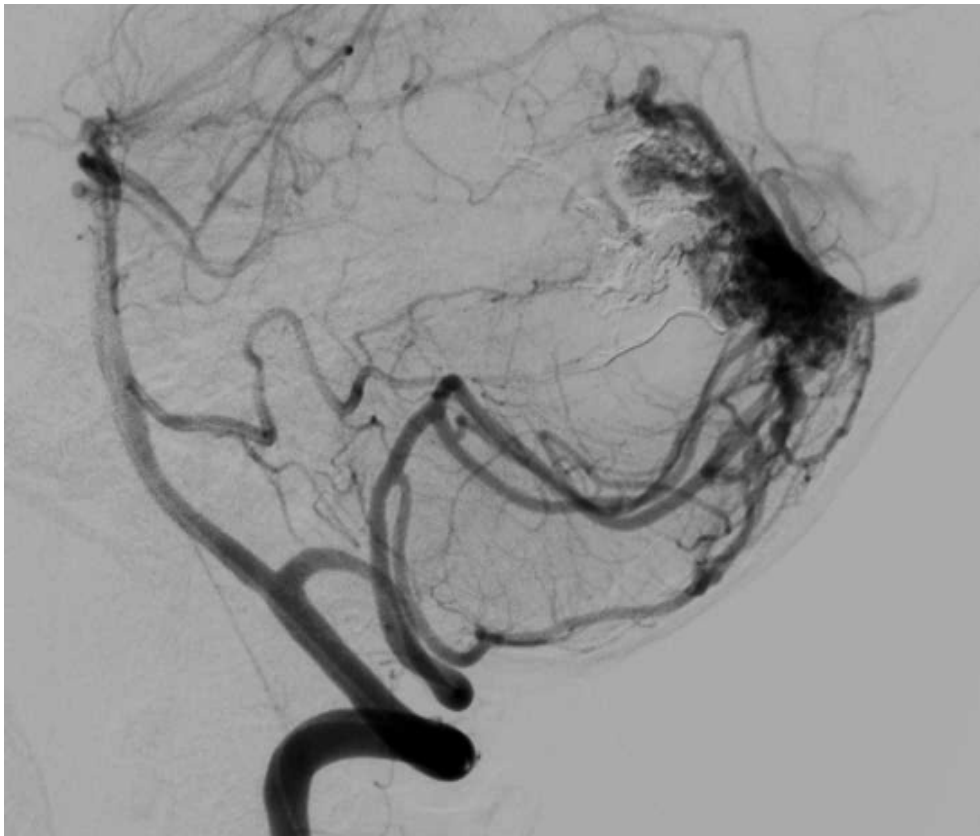
3 feeders,

more superficial

SCA approach

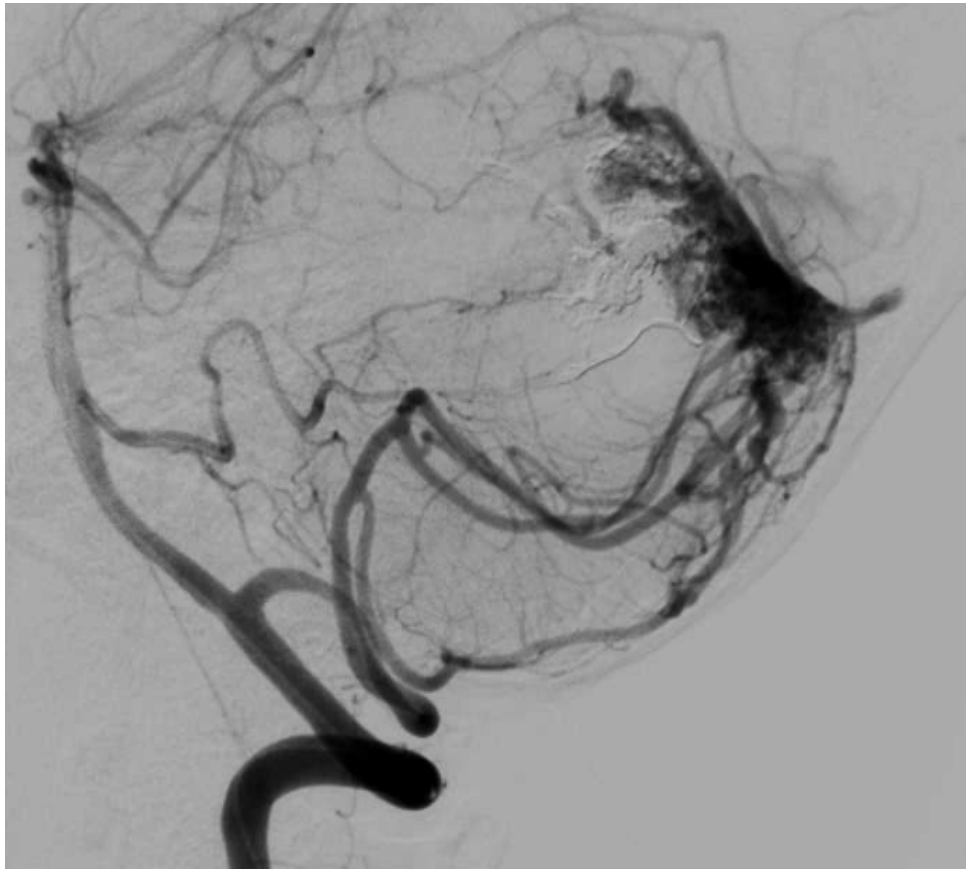


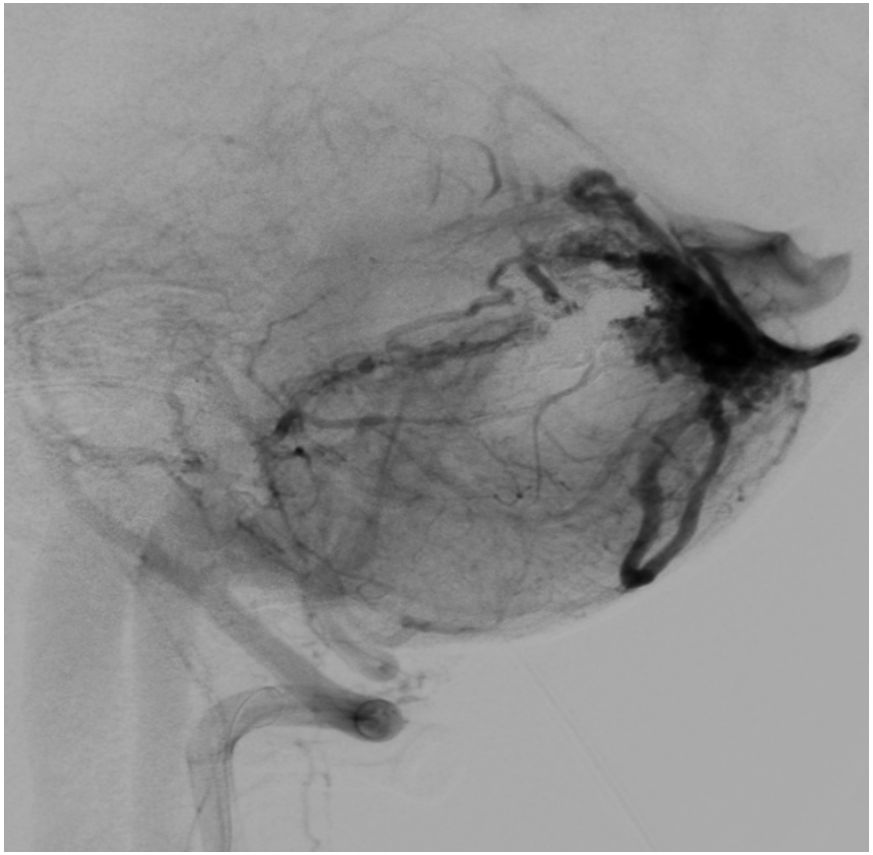
- Micro apollo (3cm detached)
- 30% occlusion



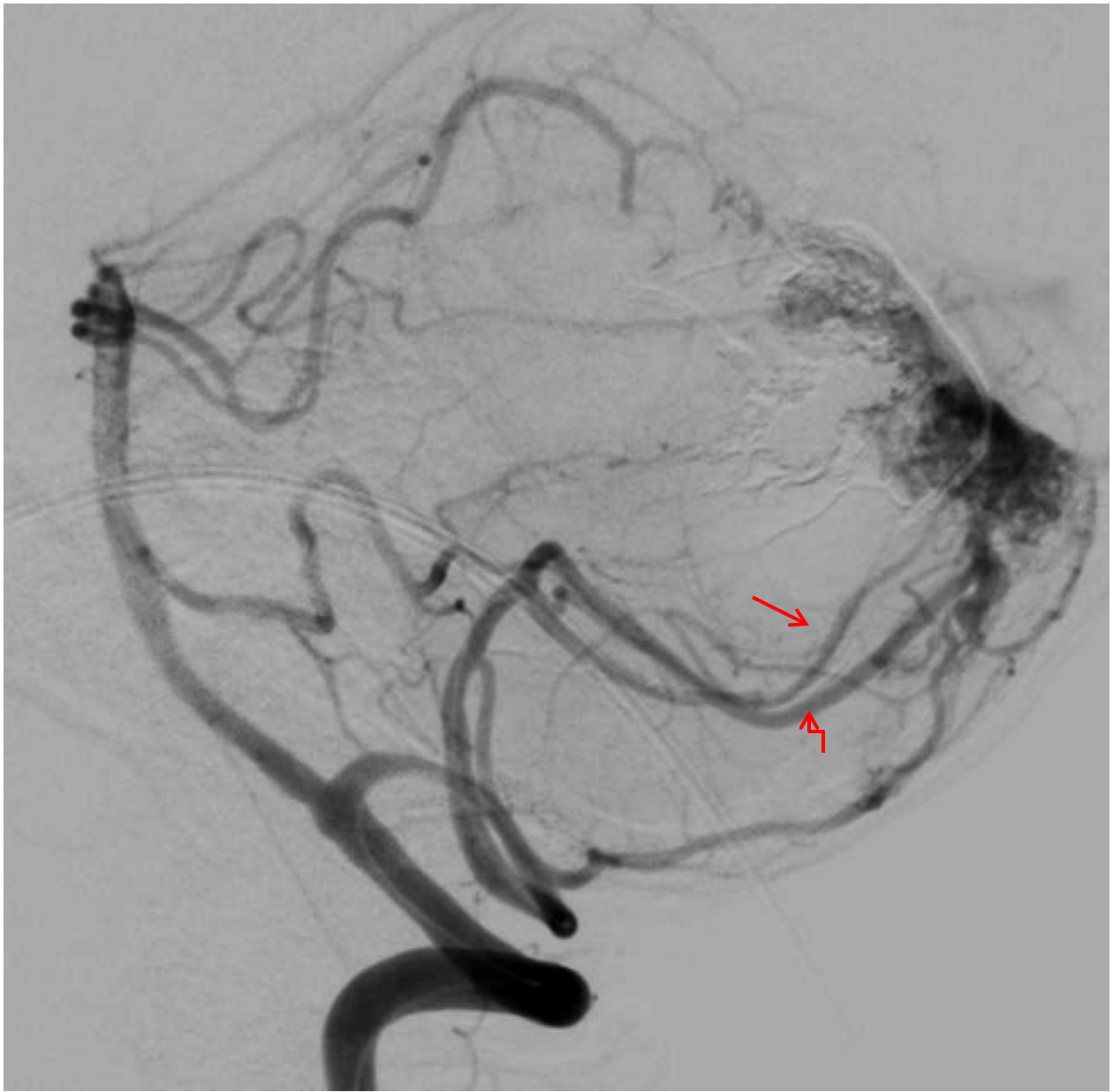
- Stagnation of the drainage veins after the first feeder embolized:

total embolization decided

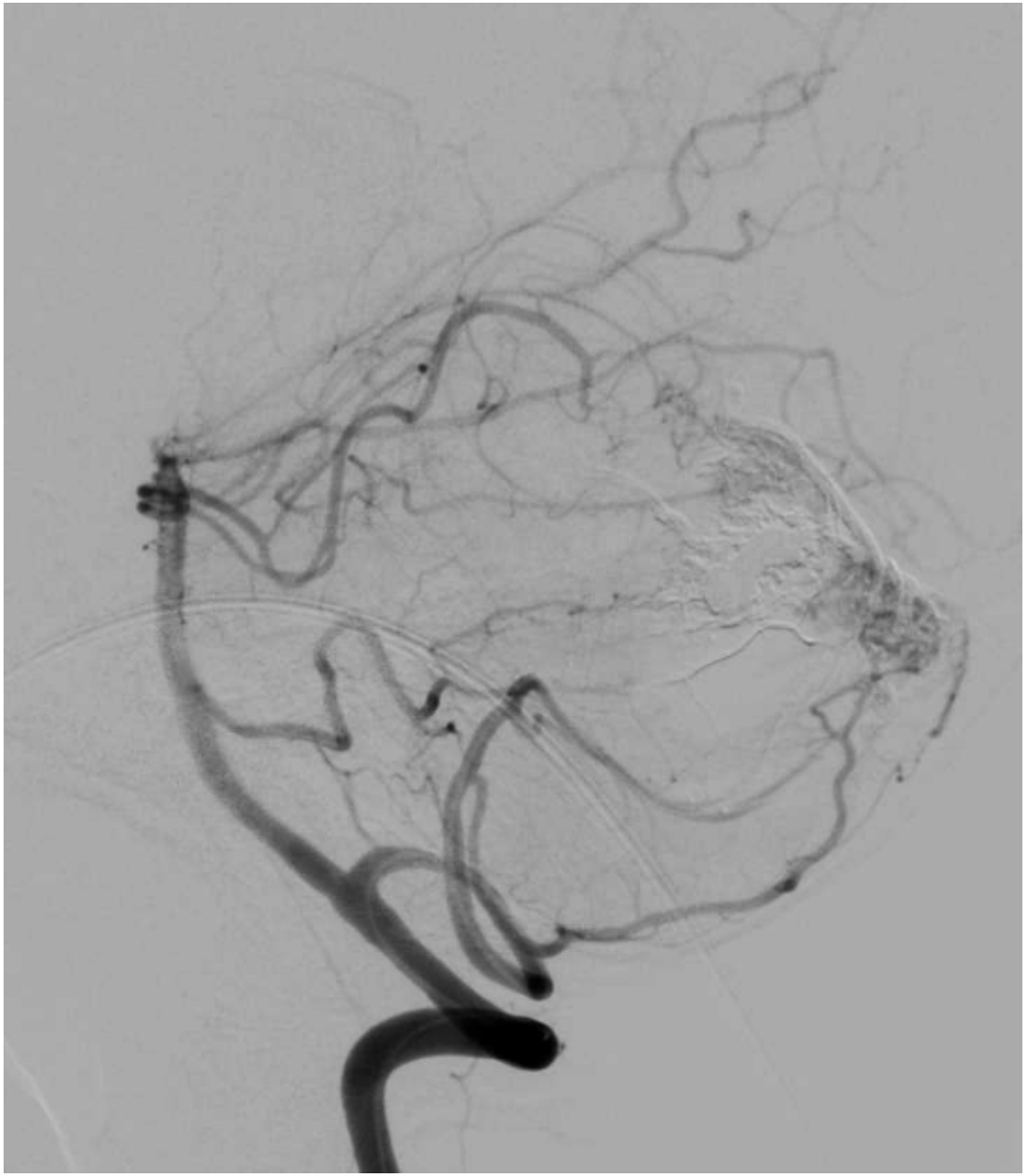




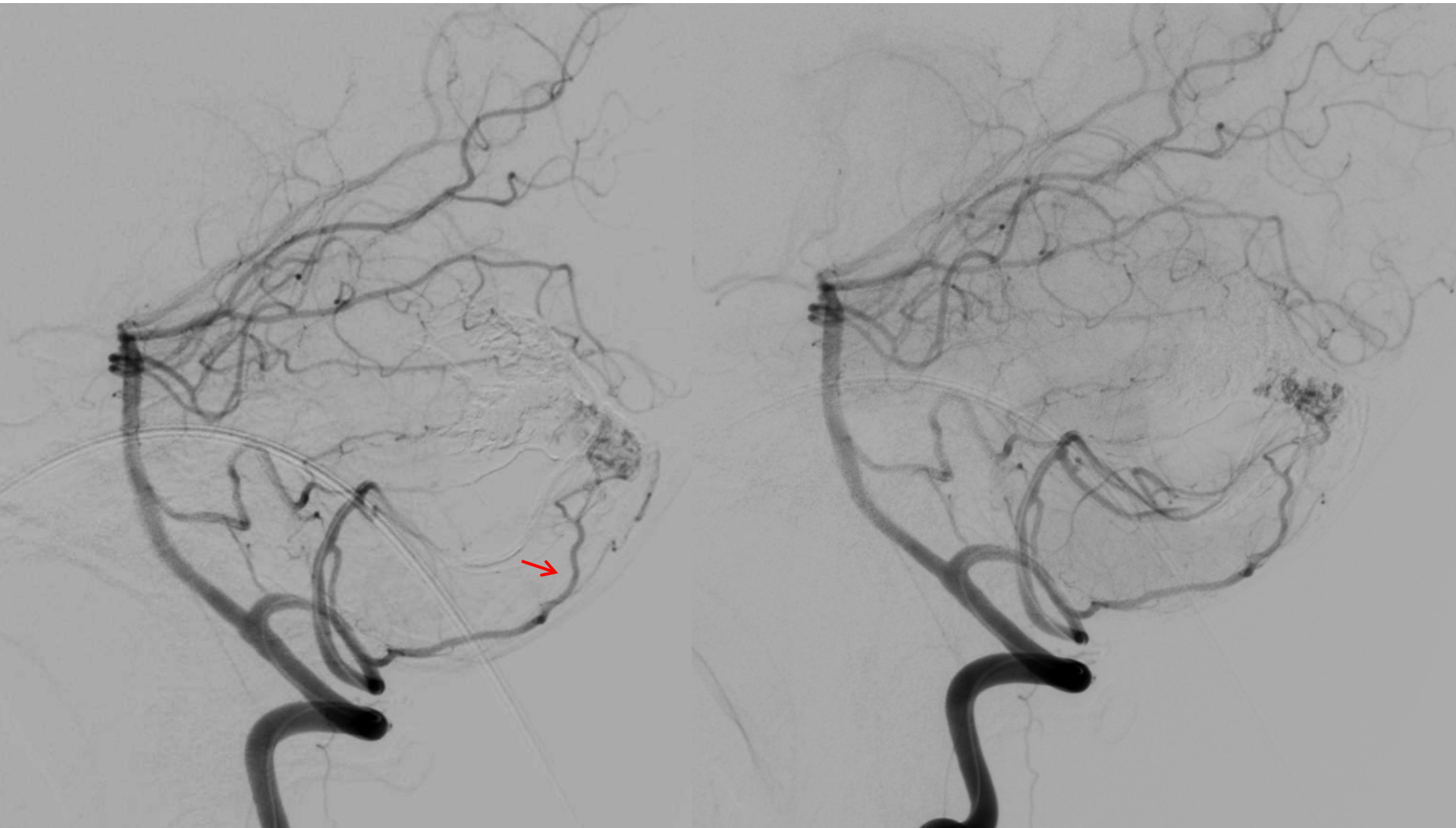
PICA approach



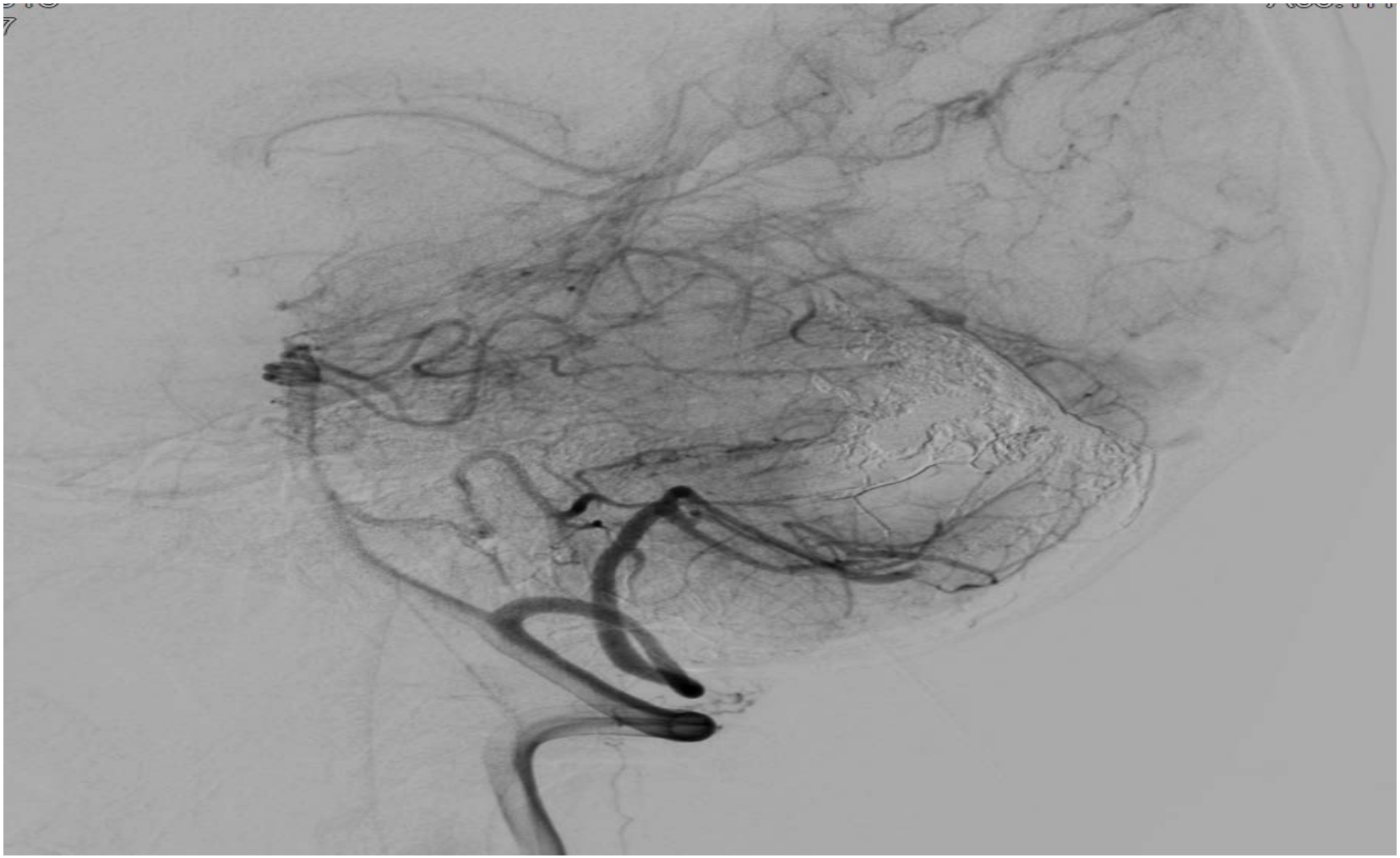
- 1st and 2 st branch of PICA approach



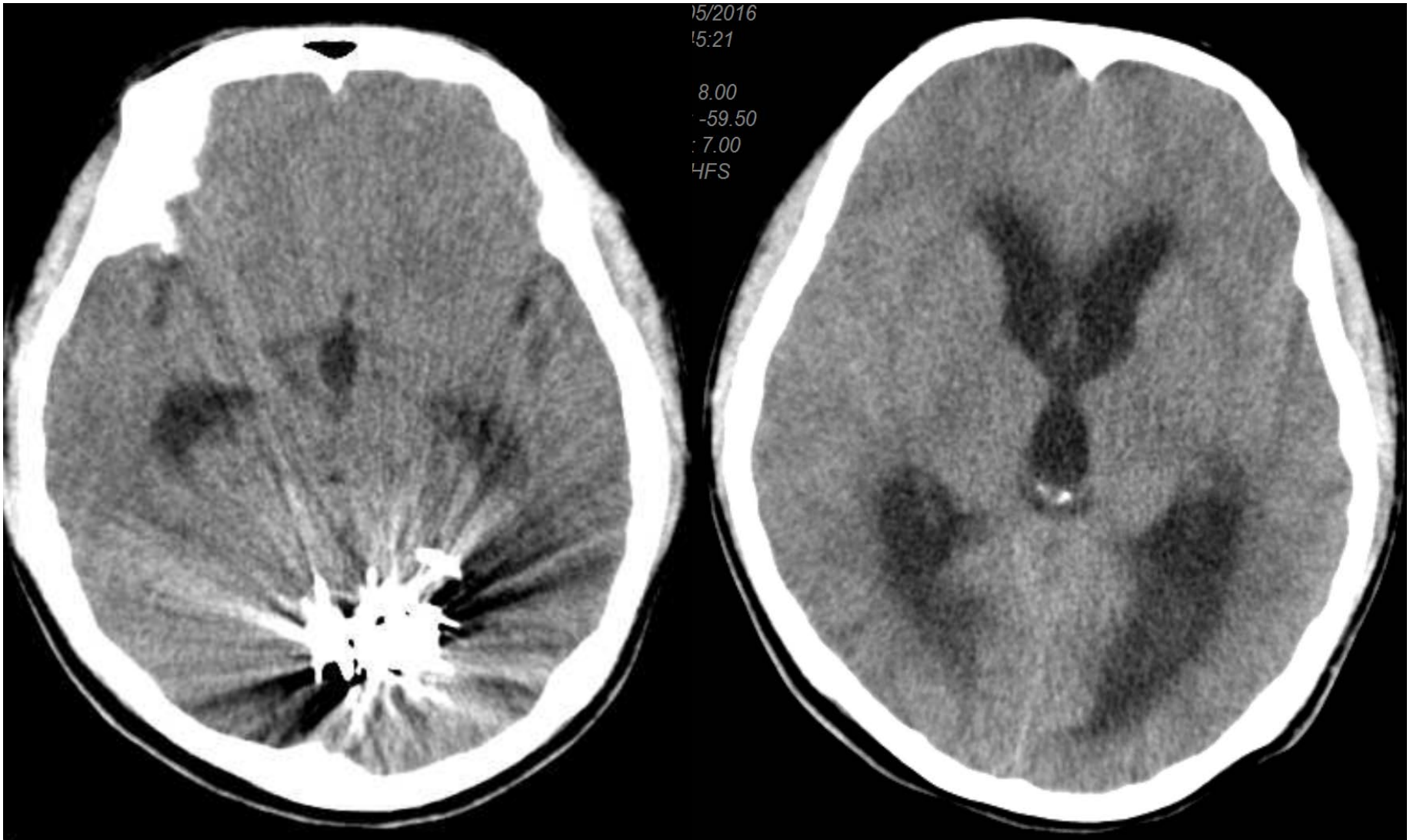
Residual AVM, without drainage vein: continue to embolise

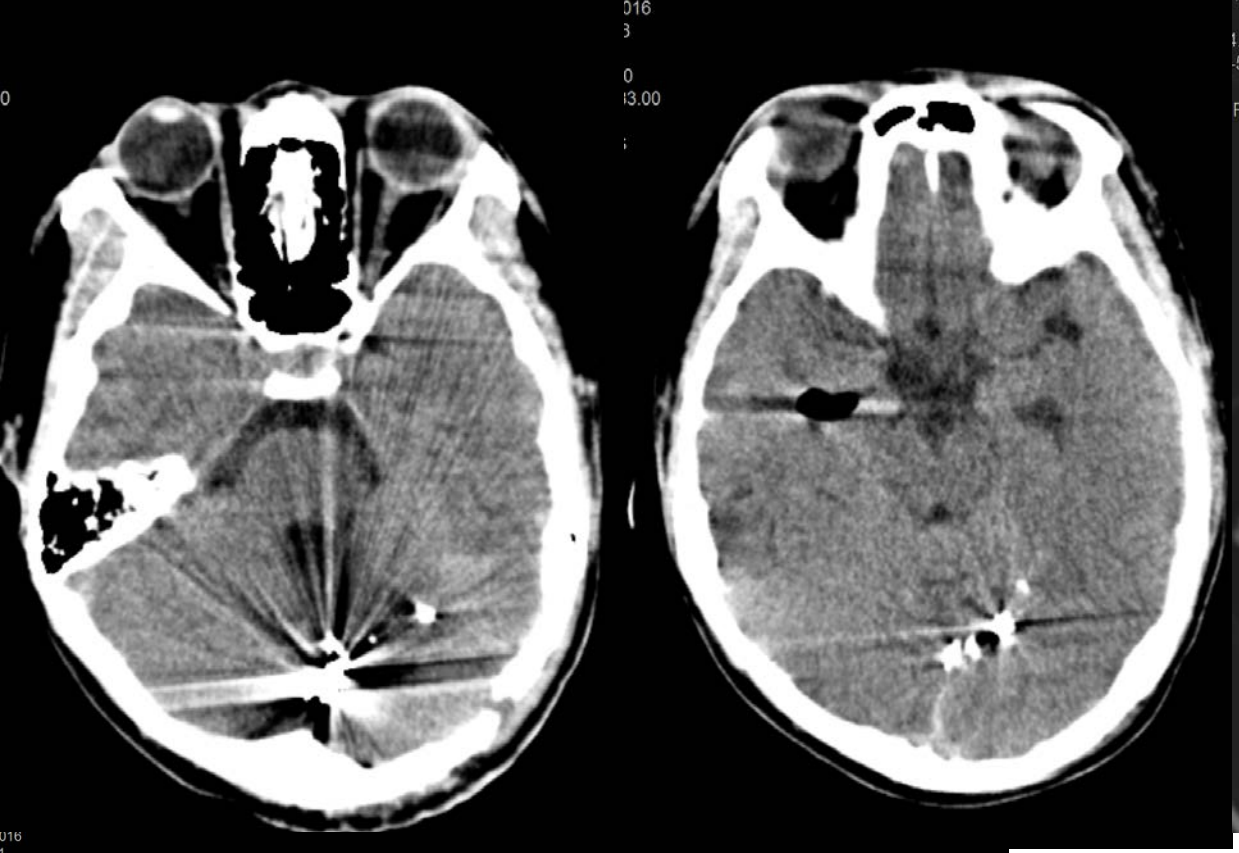


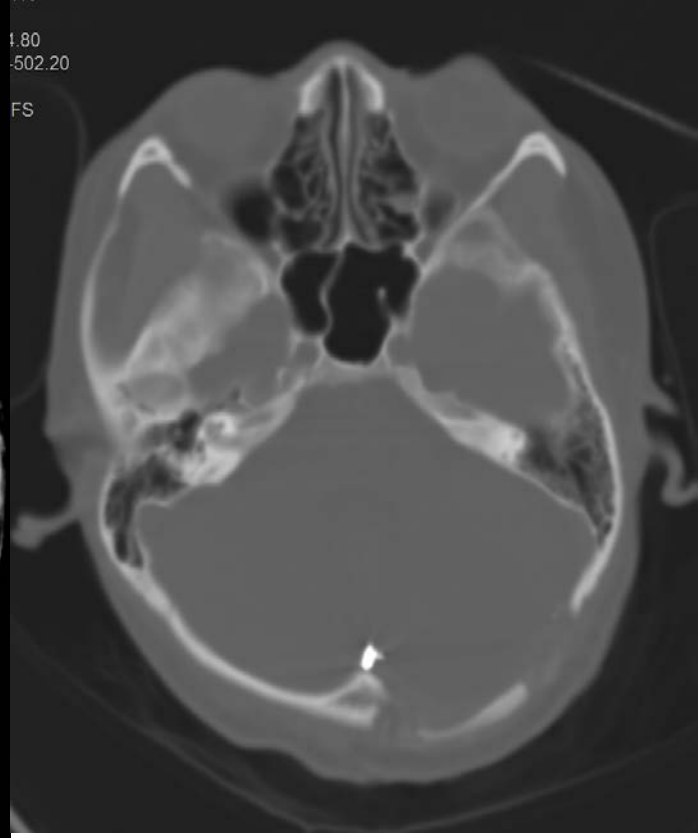
Last Control : total occlusion of the AVM

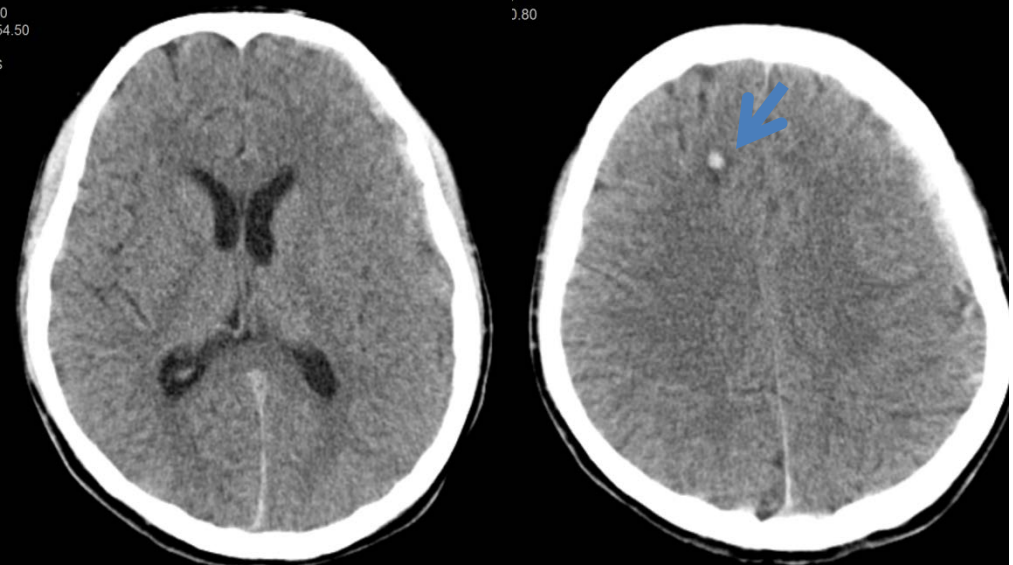


Two days after intervention









after 3 days of surgery to remove the AVM and ventricular drainage;

G15 point.

Teaching points

- Ruptured Complex AVM in the Posterior fossa
- Presurgical embolization + Surgery
- Stagnation of drainage veins during embolization: try to total occlusion the AVM
- Surgery to remove the AVM and external drainage (if necessary)