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Targeted embolization cerebral arteriovenous malformation

Although treating cerebral artery malformations (AVMS) is the ideal goal, it is often possible only with small-sized lesions. This is certainly true if surgery or radiotherapy is used as treatment tactics. Endovascular treatment, however, allows the possibility of partial treatment directed at specific areas of AVM architecture. In view of this, we reviewed our cohort of the AVM to establish which morphological areas we had identified as targets and how the treatment of AVM affected the clinical picture. Over a 36-month period 42 AVMs were treated. Patients at 22 who presented a hemorrhage with an intranidal aneurysm were identified as a target and treated in nine patients. Other patients with two patients presented with headaches (2), neurological deficits (4) and seizures (16) raised their AVM incidentally. The identified targets included the treatment of high flow fistula (12), low shireenus flow (17) and AVM (8). The results of the targeted treatment showed a lower reimage rate than anticipated by Natural History. Patients cured the best and targeted embolization reduced seizures in nine patients, neurological deficiencies in four patients and headaches in 20 patients. As long as safe methods exist to treat large AVMs, the use of targeted embolization is acceptable as it protects patients against rehemere and translates into improvements to their clinical picture. KEY WORDS: Arterial deformity, target embolization, instrate aneurysm, delayed venous, symorated fistula, natural history of arterial deformations (AVM) is considered quite benign with an annual bleeding rate of 4%. AVMS may be present along with other manifestations which may be a sign for treatment. Post-mortem shows the incidence of AVMs in the general population between 0.06 and 0.11% 7-9 and the incidence of symptomatic bleeding should be between 100 000 and 0.51 per 100 0003,2. Various treatment methods have been used in an attempt to defeat the morbidity and mortality of natural history and there are subtle variations in these methods, which in one individual case can favor one treatment method over another. These therapies in common are not all low Spetzler grades well able to treat and with high grades either appropriate (radiotherapy) or an unacceptable complication rate (surgery) 10. Endovascular treatment of a high grade AVM can alter the natural history of the AVM, even if the AVM is partially treated. We sought to assess whether we could identify targets within the AVM and we wondered whether, although in some cases we were only partially treating the AVM, it would alter natural history and the clinical picture. With this in mind we reviewed our cohort of AVM treated between 2004 and 2005 to assess whether we could identify the features we believe were responsible for the conversion of one For a medically clear AVM and what the effect of treatment had on these patients. A high flow fistula of the anterior cerebral artery. Note the passage of the artery in the vein with no interference nidus. Over a 36-month period from 2004 we treated 46 patients with AVMS. Retrospectively, we saw how these patients presented. We saw how we had treated these patients and whether we were able to identify a target before our embolisation. This post was done by looking at the procedure notes or angiogram. We saw if we had been able to successfully treat the target we had identified. The results were then correlated with the patient's clinical picture to assess whether endovascular success translated into clinical success. We also saw whether specific targets were more beneficial for treatment than others. Patients were medically evaluated as well as using a questionnaire where they were asked about seizure activity, headaches as well as general well-being. Both the GOS and the modified Rankin score were used. Finally in patients who had more than one different mode of treatment we asked the patient about their experiences and which treatments were tolerated more easily. Over a 36-month period 46 patients were treated. The centimeter and spatzler-martin are summarized in sizes tables 1 and 2 in grades. The treatment included 63 embolization, surgery on three patients and radiosurgery in two patients. Of all the patients operated on, there was embolisation before surgery and two patients treated with radiosurgery needed embolization - one after radiosurgery. Twenty-two patients were presented with a hemorrhage, 16 patients presented with seizures and the other six patients who presented with other symptoms also had seizures. Two patients had raised AVMs by chance. Two patients were presented with headaches, but 24 of the patients complained of headaches as a problem without being facilitated presenting it. Four patients presented with neurological deficit and five patients on the investigation were found to have neurological deficit although it was not the cause of the presentation. An insindal aneurysm was found in the evaluation of targets identified for endovascular treatment in nine patients. A high flow fistula was identified in 12 patients. In 17 patients there was a decrease in target shirus flow as it was felt that normal brain drainage was not normal. The target in eight patients was AVM treatment. On follow-up we had 858 months patient follow-up, which translates to 71.5 patient years. The revised Rankin scores as well as Glasgow result scores are summarized in tables 3 and 4. When a fistula was targeted, on follow-up, five patients claimed they generally felt better, the seizures in two patients were better and one patient had no further seizures. Five patients claimed their headaches were better and one claimed it was worse. Patients in which target was treated Generally claimed to feel better. Three of the patients experienced no further seizures. Six claimed their headaches were better and the neurological function of three patients had improved. Ten of the patients who were reducing the target generally claimed to feel better. The seizure activity of four patients improved and one patient had no further seizures. Eight patients claimed their headaches were better and a patient's neurological function had improved. An instrall aneurysm on the posterior cerebral artery in a patient who is presented with a bloodsucker. In short patients in which fistulas were targeted seven out of 12 showed some form of improvement, patients whose goal was to cure seven out of eight revealed some form of improvement and showed some form of improvement when ten out of target 14 toxic flows were decreasing. The results have been summarized in Table 5.TARGETIGN/SYMPTOMoverallseizsheedeurureological deficitfistula5 1 no further moves 5 betterseizures5 bettersereasedvens 10 better4 better1 no further kejisure8 better 8 better not 3 better microcathator placements only to target intranidaleureuryms. Although it was tempting to try to treat this AVM, anxiety for the calcarene artery only prompted the targeting of intranidal aneurysm. The treatment target in nine patients was an intranidal aneurysm and in each case it was felt aneurysm had been successfully embolised. We had a patient who changed again but there was no morbidity due to intraventricular hemorrhage. There were two other complications in our platoon. One was thrombo-embolic secondary to an exchange and the other was the reflux of NBCA in the labyrinth artery, resulting in ear deafness. Catheters in the two patients were removed with no complications. Patients who underwent more than one treatment method claimed that endovascular treatment was the least distressing. When more than one modalities can be used to treat one condition, the implication is that one method does not have a clear advantage over another. When the condition has a benign natural history whatever mode is used a complication should be morbidity and mortality which is less than natural history i.e. doing nothing. This is especially true for AVMS. Small variations and nuances aside, surgery, radiotherapy and endovascular embolization are all comparable and effective ways of treating small AVM. Unfortunately when it comes to larger more complex AVMs it is no longer the case when trying to treat them. Radiotherapy can only treat AVMS up to a certain amount. Surgical morbidity and mortality are unacceptably higher in large AVM - much higher than the natural history of the AVM. Endovascular embolization may be inappropriate due to the number of embolization required to fix the AVM. Sometimes more than one treatment method is used It then exposes the patient to cumulative complications. Spetzler Martin Grade 1, 10 ml volume or wounds of less than 3 cm can be treated almost equally well by surgery, radiosurgery or endovascular respectively. On the contrary, it is equally difficult to treat large AVM using any three modalities. However AVM offers benefits on the other two methods potentially due to its ability to target certain areas of endovascular treatment. The classification of AVM has reflected the treatments used. Initially because the surgery was the first treatment available for a surgical perspective was published 5, but most used now is still that proposed by Spetzler and Martin10. However it is clear that surgical classification does not fit when non-surgical treatment is used. This is the motivation behind the descriptive classification of Valanis and Yasgill that is based on the topographic characteristics of AVM11 for endovascular treatment and was also accepted by Pollock and Flickr who said that the grading system for AVMS did not predict the results in patients treated with Radiosurgery 8. It therefore depends on whether the methods of treatment are being used both by the appropriate grading system and that the appropriate results should be estimated. Where partial targeted embolization reduces the rehemerase rate partial AVM resection hemorrhage rate to natural history3,4. To double of our 46 patients increases we were only able to treat eight patients. This figure is in view of other studies where treatment varies between 10% and 40% 6. All of these patients had AVM smaller than 3 cm. It is clear that these patients fare better than patients who fail to fix their AVMs. In patients who presented with a bleeding we were only able to identify a vertradal aneurysm in nine patients. These were targeted because we agree with Valanis and Yasrgil that nidal aneurysms in particular reduce the risk of hemorrhage 11 if targeted at untreated AVMs. So there is a group of patients who are present with bleeding where there is no anesthak aneurysm as a clear target. Although our follow-up is still low we would be less than expected with the natural history of an AVM generally. Follow-up to 71.5 patients is expected to have a three bleeding for years if the bleeding rate of 4% annually is accepted. We had one. Soderman et al describes the 1tranidal fistula as a weak spot for bleeding 9. This is a goal we have chosen in patients in which an intranidal aneurysm was not seen or can be targeted. These findings are in the attention of those of Crawford et al. who showed that partial targeted embolization with NBCA reduced the long-term risk of bleeding by 24-78% when intranidal aneurysms or fistulas were targeted. The indridal fistula not only reduced the rehemerase rate but also improved seizure activity and headaches in patients. of surprise That's when the goal was decreasing More than half of the flow patients felt better and had fewer seizures and/or seizures. A patient who presented with constant agnostic movements of his hand was able to have an undisturbed all-night sleep after treating vein flow in a basal gangly AVM for the first time in years. The patients we were able to treat did very well. Deciding on a goal that cannot be cured can be straightforward when treating the AVM. An intranidal aneurysm in a patient who has blades can be seen as an objective direct target. When it comes to how a ethranial fistula is more difficult to constitute objectivity. A fistula implies a high flow hole in the shirus side and can be radiologically questionable when large caliber vessels with no interference nidus are seen and hydrodynamically confirmed when a microcathator is placed in the artery and the opposite is seen to wash rapidly. It is even more difficult to have the objective when the shirus flow from the target AVM is decreasing. Low shirus flow is assessed by comparing shireen drainage of the surrounding brain before and after embolization. If there is no delay or less delay in vein drainage of the normal brain than before embolization, it can be assumed that blood flow through AVM has decreased. The AVM veins of the surrounding brain decreases by reducing the amount of blood flowing through the crowd and this medically translates into a better picture. The improvement seen in patients when the fistula is treated can also be on this basis. Four of the five patients who underwent endovascular treatment as well as either surgery or radiosurgery patients said given the option they would choose endovascular embolization for the treatment of their AVM. Both the radiosergically treated patients preferred the embolization for radiosurgery. Finally the decision to treat AVM should ensure that the complexity of the treatment is safer than natural history. Large AVMs have a high treatment complication rate if the treatment is intended. In small AVMs where treatment is possible, it should be safely tried as these patients do the best. Targeted embolization in large AVMs is safe and beneficial for the patient. These benefits are also translated into clinical improvement. We identified four targets, namely aneurysm, vein fistula, high toxic flow, normal brain vein drainage and impair the treatment of AVM. 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