Post-traumatic vertebral artery dissection
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Introduction
Cervical arterial dissection (CAD) is a well recognized cause of ischaemic stroke, particularly in the young. It can occur spontaneously or following trauma.

Case report
A 35-year old previously healthy mechanic developed sudden onset quadriparesthesiae and unsteadiness of gait few minutes after blunt trauma to his neck from a dislodged wheel of a lathe machine. His symptoms worsened over the next 24 hours. Examination revealed horizontal nystagmus and left sided cerebellar signs. There was a contusion over the left supraclavicular region.

CT scan of the brain showed a low attenuation area in the left cerebellar hemisphere suggestive of an acute infarction (Figure 1).

CT angiogram showed eccentric contrast in the left vertebral artery from just after its origin to the level of the C4 vertebral body suggestive of dissection (Figure 2). He was anticoagulated with enoxeparin. He walked independently when he left hospital and was recommended aspirin prophylaxis.

Discussion
CAD accounts for about 20% of young strokes. Vertebral artery dissection (VAD) is up to five times less common [1]. Cervical trauma is an important predisposing factor, and CAD may follow even trivial mechanical trauma [2]. Predisposing conditions include infections, fibromuscular dysplasia, hereditary connective tissue diseases, hyperhomocysteinaemia and migraine [3]. Dissections are commonly sub-intimal and cause stenosis (48%) or occlusion (35%). Sub-adventitial dissections form pseudo aneurysms (17%), which can rupture intracranially causing sub-arachnoid haemorrhage [1]. Clinical manifestations include localised pain around the site of the dissection and effects of infarction or haemorrhage.

The most specific radiological sign for VAD is an enlarged artery with a crescent-shaped rim of hyper intense signal surrounding the narrowed lumen seen on CT or MRI scans [1]. Angiography is helpful, especially if initial

Figure 1. Non-contrast CT scan of brain with a low attenuation area in the left cerebellar hemisphere suggestive of an acute infarction.

Figure 2. CT Angiogram (a) coronal view of left vertebral artery showing filling defect (arrows) in segment II (C6 to C2) (b) Axial view of enlarged left vertebral artery with filling defect (arrow).

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Correspondence: HG, e-mail: <hemalhg@yahoo.co.uk>. Received 30 October 2009 and revised version accepted 15 July 2010. Competing interests: none declared.
imaging is negative. Antithrombotics are recommended in the acute phase of CAD to prevent primary or recurrent ischaemic events. However, no randomised trial has been done to test the efficacy of this treatment. CAD carries a good prognosis in about three-quarters of patients and VAD has a better functional outcome when compared to carotid dissection [1].

References

An injury resulting in vaginal evisceration

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Introduction

Vaginal injuries following perineal trauma are relatively rare. Vaginal evisceration is even rarer accounting for less than 1% of all trauma to the perineum [1]. These injuries are associated with minimal symptoms and signs. Perineal or lower abdominal pain with vaginal bleeding are the common complaints and investigations such as erect abdominal x-ray or abdominal ultrasound may not demonstrate the extent of the injury. Vaginal speculum examination, proctoscopy and cystoscopy are important in the evaluation of the patient. CT is useful if peritoneal involvement is suspected.

Case report

A 12-year old girl gave a history of impaling injury to the perineum while she was sliding on a tree trunk. She experienced mild vaginal bleeding and pain at vulva. She did not notice any abdominal pain, retention of urine, haematuria or bleeding per rectum. Her abdomen was not tender and vaginal examination revealed a yellowish lump at the posterior fornix of the vagina with bleeding (Figure 1). Digital rectal examination and proctoscopy showed no injury to the rectum. She was haemodynamically stable.

Ultrasonography of the abdomen showed a fibrous, band-like echogenic structure extending through the bladder from its anterior wall towards the vault of the vagina. It was difficult to identify the structure with any certainty. CT on the abnormal structure was shown to be a part of an abdominal content coming through the bladder to reach the posterior vaginal wall.

Exploratory laparotomy was done. The omentum was plugged through the posterior wall of the bladder. Cystoscopy showed the omentum crossing the bladder from its anterior to posterior walls between the two ureteric

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