

<b>Case</b>	(730) Posterior inferior cerebellar artery (pica) subacute stroke who causes upward transtentorial herniation
<b>Authors</b>	
<b>Centre</b>	

C. Simón Bejarano, L. Sánchez Linares.

Hospital Regional Universitario.

## CASE PRESENTATION

A 77 yo male with HTA and DM II is sent to our Centre from another hospital for neurosurgical valuation with cerebellous mass diagnostic was made in non contrast brain CT. 48h before the patient started with nausea, vomiting, dizziness, unsteadiness and headache.

At arrival was noted horizontal nystagmus. Due subacute clinic and radiologic features (hypodense area in left cerebellous with vascular distribution who suggested stroke, and who effects an important mass effect and supratentorial hydrocephaly and upward tentorial herniation) we decide complete study with angioCT.

The angioCT showed left vertebral artery partial occlusion who involved the proximal portion and an only central repletion defect who suggest embolism; after the defect the artery was not occluded. Left posteroinferior cerebellar artery was not occluded. Due to the study didn't show another radiologic finding who suggested arterosclerotic disease in main intra and extracranial vessels and due it showed an unice central repletion defect we reported as an subacute ischemic in PICA's territory with probably cardioembolic origin.

After this the auricular flutter was done (major source for cardioembolic disease) the stroke suffered an haemorrhagic transformation and the patient started with upward tentorial herniation clinic a posterior decompressive craniectomy was performed.

## DISCUSSION

Cerebellar infarction its an relative uncommon subtype of ischemic stroke, however, their true incidence may be much higher, since most cerebellar infarcts are small and may remain unrecognised cause many of the symptoms of cerebellar infarction are nonspecific, such as nausea, vomiting, dizziness, unsteadiness and headache, and the clinical diagnosis relies on focused neurological examination and a reasonable index of suspicion. Examination findings include incoordination, ataxia and horizontal nystagmus.

They usually tend to involve cerebellar cortex while larger cerebellar infarcts in general involve the cerebellar cortex with a varying amount of adjacent white matter ("arbor vitae"), most small cerebellar infarcts involve the cerebellar cortex in isolation, thus with sparing of white matter. Typical features of infarction such as early loss of greywhite differentiation, hypoattenuation and edema may be identified in the relevant vascular territories.

The mortality related due to concomitant brainstem infarction, or compressive hydrocephalus, rarely complications upward tentorial herniation as happened in this case.

## CONCLUSION

Extensive cerebellar stroke is unusual and should not be confused with cerebellar mass. If the study only shows an only central repletion defect and we can not find another radiologic features who suggested arterosclerotic disease in main intra and extracranial vessels cardioembolic origin could be suggested.



## BIBLIOGRAPHY

- Cormier PJ, Long ER, Russell EJ. MR imaging of posterior fossa infarctions: vascular territories and clinical correlates. Radiographics 1992;12:1079–1096.
- Nouh, A., Remke, J., & Ruland, S. (2014). Ischemic posterior circulation stroke: a review of anatomy, clinical presentations, diagnosis and current management. Frontiers in neurology, 5, 30.