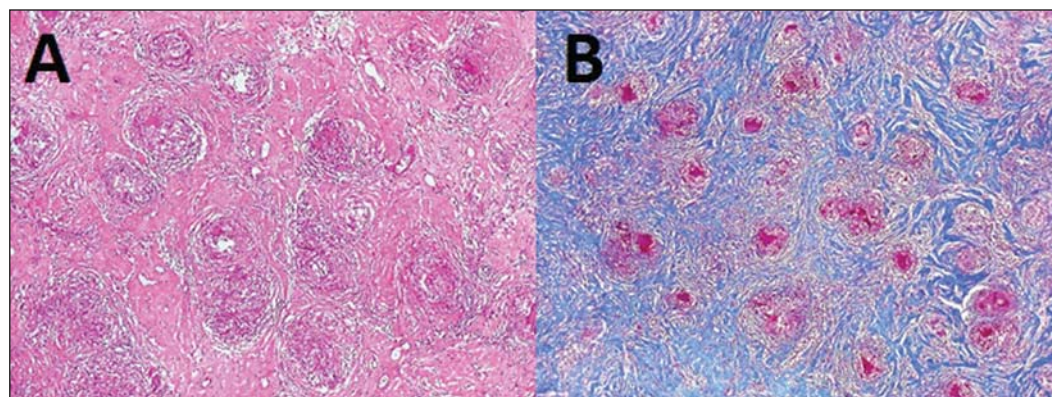


Figura 2. A: Biópsia de área espessada de dura-máter demonstrando numerosos granulomas não caseosos de células epitelioides e gigantes, e infiltrado inflamatório de predomínio linfocitário, em meio a densa fibrose colágena. **B:** Tri-crômico de Masson: destaque dos granulomas contra o denso tecido conjuntivo colágeno.



A ocorrência da sarcoidose no sistema nervoso central está estimada em torno de 5–15%. É raro o paciente apresentar manifestação neurológica exclusivamente, como no caso aqui apresentado, sendo mais comuns os casos de neurosarcoidose quando há doença disseminada⁽²⁾.

As manifestações clínicas da neurosarcoidose são pleomórficas. Comprometimento de nervos cranianos, alterações visuais, cefaleia, fraqueza, parestesia, alterações psiquiátricas e sinais de irritação meníngea podem ser observados. Sintomas de diabetes insipidus também podem ocorrer, embora sejam mais raros, como sede e poliúria, em razão de acometimento do hipotálamo e hipófise. Quando há acometimento da medula, manifestam-se intensa fraqueza em membros inferiores e outros sinais não específicos de mielopatia⁽³⁾.

Embora a neurosarcoidose possa aparecer em todas as regiões do sistema nervoso, é mais comum que ocorra na base do crânio, hipotálamo-hipófise e quiasma óptico⁽⁴⁾. Um dos achados mais comuns na ressonância magnética são as lesões intraparenquimatosas com hipersinal nas sequências em TR longo (T2 e FLAIR), sendo geralmente multifocais periventriculares, subcorticais ou na substância branca profunda. Tais achados são indistinguíveis de vasculites ou de doenças de substrato desmielinizante. Lesões intraparenquimatosas geralmente estão próximas de áreas com acometimento leptomeníngeo (com realce pelo contraste paramagnético) e podem ser únicas ou múltiplas, e envolver também nervos cranianos⁽⁴⁾.

Espessamento paquimeníngeo difuso, com hipossinal em T2, isossinal em T1 e realce pelo meio de contraste, pode também, como no nosso caso, ser observado. Assim, diagnósticos diferenciais, como neurotuberculose, linfoma dural, meningioma em placa, depósitos de IgG4, pseudotumor, metástase de adenocarcinoma, granulomatose de Wegener, paquimeningite hipertrófica

idiopática, podem ser considerados, sendo a biópsia necessária para definir a etiologia. É raro o acometimento simultâneo dural e leptomeníngeo⁽⁴⁾. No caso aqui apresentado, os achados de anatomia patológica mostraram granulomas típicos não caseificados na paquimeninge (Figura 2). Outro diagnóstico diferencial a ser considerado é o de hipertensão intracraniana, que apresenta, geralmente, um espessamento paquimeníngeo difuso, porém com hipersinal em T2 (neste caso, havia hipossinal em T2).

Ainda não há um consenso sobre o tratamento da neurosarcoidose. Quando o paciente é sintomático, iniciam-se altas doses de corticoide, que podem ser reduzidas ao longo do tratamento e até retiradas⁽³⁾.

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Femoral artery injury during aneurysm coiling

Lesão da artéria femoral durante embolização de um aneurisma

Dear Editor,

Endovascular artery reconstruction with low-profile stents, flow-diverters and flow-disrupting devices represent a significant progress in the endovascular therapy of intracranial aneurysms. Despite the improvement in technical expertise and developments in device technology, endovascular treatment still has inherent risks⁽¹⁾. In the literature, most reports are focused on neurological complications during procedures⁽²⁾, however, reports on access vessel complications are scarce. Some of the well known access-related complications include: arterial pseudoaneurysms, arterio-

venous fistulae, hematomas, arterial dissection leading to acute vessel occlusion^(3,4), intracavitary bleeding, and retroperitoneal hematoma following femoral artery puncture⁽⁵⁾. The authors report the case of a large groin hematoma caused by a hypodermic needle connected with the black cable of the detachable coil power supply (Boston Scientific; Natick, MA, USA) and its endovascular management.

Local compression is the first line treatment for femoral access complications⁽⁶⁾, but such strategy may fail when indicated for patients under combined antiplatelet and anticoagulation regimens. Open surgery is effective in the treatment of groin complications⁽⁷⁾. However, the endovascular approach is a safe and effective minimally invasive alternative to surgery in the management

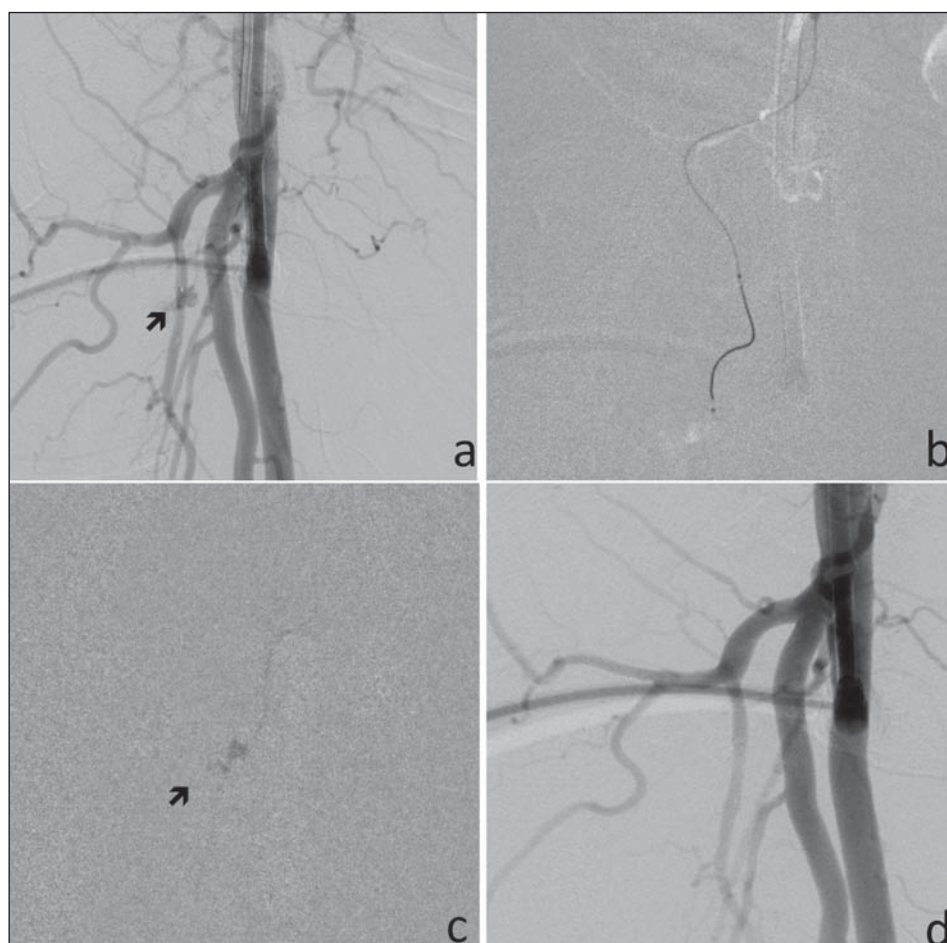


Figure 1. **a:** Angiography of right femoral artery (RFA) shows the 7F sheath inserted into the common femoral artery and an active contrast extravasation (arrow) in a small branch of the deep RFA, consistent with active bleeding. **b:** Microcatheter placed into a small muscular branch of the deep RFA. **c:** Microcatheter for glue injection into the small muscular branch of the deep RFA and contrast extravasation (arrow). **d:** Post-treatment RFA angiography shows absence of bleeding.

of access vessel complications^(8–10). A bleeding originated from an arterial access can be treated by endovascular approach using either liquid or coil embolization^(8,9), or by stent-graft implantation⁽¹⁰⁾. In the present case, selective embolization was performed with N-butyl-2-cyanoacrylate because the bleeding site was located in a thin distal branch of the right deep femoral artery, allowing for micro-catheterization and injection of a liquid embolic agent. In the present case, the very small caliber of the bleeding vessel precluded the use of coils. Moreover, because the bleeding was located in a distal branch of the deep femoral artery, and not in the wall of the artery, there was the option for selective embolization instead of stent-graft placement. Selective arterial embolization avoids potential risks associated with a stent-graft implantation, such as thrombosis, kinking, compression, occlusion of femoral branches and long-term stent occlusion.

The present case reveals an unexpected complication during aneurysm embolization and alerts us to the possibility of uncommon bleedings secondary to simultaneous use of aspirin, clopidogrel, and unfractionated heparin.

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