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Intra arterial thrombolytic therapy

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A MicroCatheter Velocity (Penumbra, Alameda, California) has been initially used to attempt SCA access but without success. A second attempt was done with a Headway Duo (Microvention, Aliso Viejo, California) A 6 a small microcater, plus foldable better suited to the acute turning point in the SCA. A dose IA TPA 2 mg has been administered to the site of the occlusion. A technique of first passage direct aspiration (ADAPT) and Retriever Stent were designed to be too aggressive in a small SCA. The vessel has been recanalized proximal, and the microcater has been advanced to the distal occlusion site before the administration of another 2 mg of TPA. Race Post-Tpa showed excellent SCA Rivascularization. For the occlusion of the small intracranial vessels where IV TPA is ineffective and mechanical thrombectomy is dangerous, the local administration of IA TPA can be an effective therapy.consent state obtained from the patient before performing the procedure. Institutional Review Board approval is not necessary for the report of a single case. Intra-arterial, superior cerebellar artery The use of intra-arterial tissue activator of acute section plasminogen: video case Doctori Siddiqui reports as follows: Financial interest / Investor / Options Archive / Property: Amnis Therapeutics, Medica Apama, Blinktbi, Inc, Buffalo Technology Partners, Inc., Cardinal Health, Medical Systems Cerebrotech, Inc, Medical Claret, Medical Cognition, EndoStream Medical, Ltd., Imperative Care, International Medical Distribution Partners, Rebound Therapeutics Corp., Via della Seta Medica, Stimmed, Synchron, Three Rivers Medical, Inc., Viseon Spine, Inc. 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Know our initial view remote access options Posted by: 6 April 2021 Financing information: This study was funded by the Natural Natural Science Foundation of China (81,772.085). Guuwen Zhou is co-first author. The incidence of acid (HA) Embolia has increased considerably in recent years. It has Embolia can lead to serious complications such as cecieta, eyes and disorders of the movement of eyelids, skin necrosis, and cerebral embolism. However, there is a lack of solid clinical evidence regarding the benefits of the of Embolism of ha with intra-arterial thrombolytic therapy (ITT). In the present study, we have recorded 45 patients with reduced visual decrease, including 40 patients with vision loss symptoms and eight patients with symptoms of intracranial embolism. Patients were submitted to Emergency ITT through injections of hyaluronidase and papaverini, followed by conventional sequential therapy. In the 45 patients with symptoms of vision loss, 16 (36%) showed improvements in the final visual affair, even when the clinical application of thrombolytic treatments was performed beyond the recommended window for optimal treatment. Facial skin necrosis of all patients has been restored for normal appearance. In particular, for eight patients with suspected symptoms of intracranial infarction we performed cerebral and IATT angiography, and in two patients obtained the partial embodiment of obstruction, the symptoms of headache and binocular pain were improved in a patient with intracranial embolism After IATT treatment. Our results indicate that IATT is feasible for patients with embolia-induced vision loss. ITT combined with conventional sequential therapy was advantageous in the recovery of other serious emblem complications of embolism. However, the underlying pathophysiological mechanism must be clarified in future animal experiments. The cosmetic injection of hyaluronic acid (AA) is a minimally invasive and nonurgatic rejuvenation therapy, used in China and abroad. It is effective and unavailable and significantly reduces downtime. It was able to be used as a soft fabric filler given its glycosaminoglycan structure, which promotes water retention and consequently volumes and outlines the contour of the skin.1 with the rapid application of HA injections, the numbers of cosmetic complications reported have also increased incompletely. Although localized reactions of the injection site can be temporary, skin echymosis, edema, local pain, and even serious complications have been persecromitely reported. 1 Among these complications, arterial occlusion (shows in figure 1) is a rare condition But devastating that it can bring necrosis or cecieta to the skin, or even intracranial embolism. Unless it is appropriately managed, the resulting vision loss could be irreversible. Intra-arterial thrombolytic therapy (IATT) is considered a practicable treatment strategy for ships embolism and is considered an appropriate option to treat the complications of HA injections. In the current study, we aimed at evaluating the effectiveness of ITT in cases with embolisms of cosmetic face of the face has. Therefore, we have revised retrospectively the cases of 45 patients with severe vision loss, motivation eye disturbance, ptosis and skin lesions, together with intracranial embolism attributed to the cosmetic injections of the face to HA. All patients received the IATT emergency on admission. In this study, we evaluate our methods of treatment together with the associated effectiveness, in order to better manage the serious complications caused by AB's face injections. Schematic drawings of vascular anatomy with ophthalmic artery and its branches. The yellow lines indicate the optical nerve and the back wall of the eyeball. The alleged level of injection content is shown as a solid round (ha) revised retrospectively the case of history of patients diagnosed with ophthalmic artery and / or the occlusion of retinal artery due to cosmetic face injections and which They have undergone the IATT with transphemoral cerebral angiography to our hospital department between 1st January 2017 and 31 December 2018. We performed magnetic resonance and TC to exclude infarct or intracranic before IATT. Shortly after the strict control of the IATT contraindications, such as hypertension, coagulopathy, intracranial and external hemorrhage, and obtaining the informed written consent, was considered for most patients who presented within 24 hours after the onset Symptoms. After a particular ophthalmological ophthalmologic a microcatheter was inserted into the femoral artery, and has been performed digital subtraction angiography (DSA) together IATT. In short, DSA has been performed at the proximal bifurcation of the internal and external carotid arteries with a DSA angiography machine, and IATT was subsequently performed after written informed consent was obtained. DSA has been performed in the proximal part of the bifurcation of the internal and external carotid angiography using a machine (Philips, FD20). After eye artery dysplasia detection, a microcatheter (STRIDE 2.6-Fr, ASAHI, INTECC , catheter gooseneck and Carmelian 1.8 catheter in wheat Ruitong Ltd., Doctors TOKAI, products, INC) has been placed in the proximal part of the ophthalmic artery, and a thrombolytic agent (hyaluronidase) and vasodilator (papaverine) were slowly injected with mechanical breakage with a microguidewire (Streaming 0.14, 0.18 microguidewire, ASAHI INTECC) distally to remove emboli. The hyaluronidase dose ranged from 500 units and 1500 units, while papaverine dose ranged up to 30A mg. We retrospectively analyzed patient data demographic and clinical characteristics, in the light of DSA images. We performed cerebral angiography, locating the headquarters of embolic obstruction on the angiogram ophthalmic; subsequently, the distal outflow angiographic model has been labeled with an angiogram external carotid artery, according to the lesion skin necrosis. After HA embolization, patients were promptly administered oxygen inhalation. multilayer hyaluronidase injections were implemented in primary embolism area to dissolve the HA has been stacked beneath the skin and to reduce the local voltage. In addition, vacuum sealing drainage dressing was used in patients who had wounds of facial skin on skin necrosis, significantly promoting wound repair. waiting treatments were performed: succinate pulse glucocorticoid therapy (methylprednisolone sodium (1000a mg, IVGTT [> 30A min], qid, 3a days) treatment for edema (mannitol, 125A ml [25A g], IVGTT, Q6a h ; tablet Melilotus extract, 50 6 100A mg, po, tid) and neurotrophic treatment (rat nerve growth factor injection, 20a A A½g, qn ; Mecobalamin injection, 0.5A mg, IVGTT, qid, 90th day) some patients receiving single postfrontal injection depending on their specific conditions (20a 2.5a mg mg tobramycin and dexamethasone). in addition, the compound anisodine hydrobromide (2a ml, qid) was injected into the temples. According to the degree of conjunctival edema, prednisolone acetate eye drops, levofloxacin, and deproteinized calf blood extract eye gel were selectively used. scavenging of oxygen radical treatment edaravone used. patients with intracranial vascular embolism, detected by magnetic resonance imaging, were administra ati edaravone to remove oxygen free radicals, butylphalide to protect mitochondria, and dehydration treatment with fructose glycerin to reduce cranial pressure. Most patients could not adapt to the convalescence of visual disability, insomnia and other symptoms of depression, and, therefore, the psychological team administered drugs and other psychological interventions. Patients were followed for 1A month for 1A years (mean follow-up: A 3 months). In this study, we included 45 patients with HA ophthalmic artery occlusion after injection of facial aesthetics, including 39 young women and six men (mean age, 26 a year). All 45 patients had a reduced unilateral and bilateral vision (right eye at 10, 22 in the left eye, and both eyes 3). The nasion area was the most common HA (49% of the injection site, 22/45), which result in ophthalmic artery occlusion. The second most common site is the frontal area (42%, 19/45), followed by the glabella = A, 2). Temporal area (n = 1 A.). 83% (20/24) of patients did not receive immediate IATT after embolism has occurred, but the treatment received with vasodilator agents, glucocorticoid therapy, or neurotrophic drugs in the other hospital. They hadn't had improvement of visual housing. However, eight patients with intracranial embolism presented to our hospital by directly following the onset of symptoms, and emergency received IATT and cerebral angiography, along with other symptomatic treatments. In total, 89% (40/45) of patients presented with sudden loss of sight immediately and Ophthalmodynia during the injection of ha, together with the impossibility of opening eyes, dizziness, nausea, vomiting, strong headache, numbness And the skin. Furthermore, 18% (8/45) of patients showed intracranial infarction on cerebral angiography. As regards the visual acuity deficit, 25 patients exposed capably skilled (no light perception [NLP]) during their first presentation in our hospital. However, four patients showed the perception of light (LP). All patients showed the Midriary with a student diameter> 5 mm and ptosi exhibited. Forty-one patients presented with ocular motility disorders. In particular, 43 patients showed skin lesions in the corresponding artery occlusion region, who manifested pale, piebald, or necrotic. Of concern, 68.89% (31/45) of embolished patients received injection of hyaluronic acid before and after menstruation or even during menstruation. Following IATT, the recereationalization of the ophthalmic artery and its branches could be clearly observed on DSA (Figure 2). Meiorating retinal blood supply and arterial recanalization were observed via Fundus color photography (Figure 3). Furthermore, the 36% visual acuity (16/45) of patients was immediately improved after IAT. The visual acuity of these 16 patients continued to improve the following sequential complete treatment. Furthermore, IATT has significantly improved the skin necrosis and skin Echsis and the appearance of normal skin has been restored in all patients. Some surface scars have remained in some patients. Angiographical results of a patient of 45 years after the injection of hyaluronic acid in the glabella. The angiography of Fluorescein shows the retinal and coroidal perfusion delayed late, choroidal perfusion, fluorescence losses on the edge of the papilla and macula and the insufficient filling of the upper temporal vein (A). The angiography of the fluorescein on the third day after intra-arterial thromboly shows a clear invention of retinal artery perfusion (arrows shown in b) in the background photographs of the upper and nasal long thunderstorm color background showing the macula before e 1 After the thrombolisy. (A) The area of Macula is bleeding (circle), and retinal artery is obstructed (arrowhead). (B) One day after thrombolysis, macular hemorrhage in the temporal papilla was gradually absorbed (circle). The arrows indicating the position of retinal arteries, above the temporal region, show obstructions marked after intra-arterial thromboly therapy (IATT) Thromborapia intra-arterial Thrombolica and cerebral angiography were performed in eight patients with intracranial infarction. Table 1 summarizes the demographic characteristics, clinical features and the results of cerebral angiography of these patients. Patients were for the more feminine and young people (middle age, 26 years). They received facial fillers in the glabella area and / or the back of the rhinoplasty nose. All patients had a widespread occlusion, including the complete occlusion of the ophthalmic artery or branch's occlusion. The skin necrosis was observed in six of eight patients after the injection of ha and all the patients were treated with the injection of subcutaneous hyaluronidasis without any severe skin scars. All patients presented to our department within 10 hours later Symptoms and were subjected to IATT the same day. However, the results of the thrombolisi were unfavorable, since only two patients were subjected to partial embodiment of the obstruction (Table 1). Furthermore, the visual acuity was not objective at the end, because, in the final evaluation, five patients had NLP, two had LP, and one exhibits the perception of the movement of the hand (HM). In a patient with intracranial embolism after IATT treatment, symptoms of headache and binocular pain of relaxation distension Improved, even if the examination of the fund in this case had little vascular development of the retina. After 2, days, the patient was again treated with IATT, and clinical symptoms had relieved. After 3a, days, the patient has paroxysmal migraine and progressive aggravation, and the CT emergency head indicated multiple brain hemorrhages on the left side of the front, parietal and time zone (figures, 4a, C, e), as well as

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