Aneurysm Of The Internal Jugular Vein And Transverse Sinus Associated With Occipital Bone Erosion

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Citation

Abstract
Internal Jugular Vein (IJV) aneurysm is exceedingly rare anomaly. Written data on this anomaly is rare in literature. This report presents a case of IJV aneurysm associated with transvers sinus aneurysm and occipital bone erosion.

INTRODUCTION
Anomalies of IJV are infrequently encountered in the literature. It has been described by various names as; phlebectasia, congenital venous cyst. IJV aneurysms usually present in childhood with asymptomatic mass in the neck which increase its size with valsalva maneuver, coughing, straining etc. We report a case of IJV aneurysm associated with transvers sinus aneurysm and occipital bone erosion, that this combination is the first in literature.

CASE REPORT
A 58 year old woman presented with non-pulsatile mass in her neck. It had been present for 3 months but the erosion on her occipital bone exists from the birth. The patient was born after normal pregnancy and delivery without any special neonatal events. Beside this she has no symptoms and no history of previous trauma or surgery. The mass increases its size with increased intrathoracic pressure (Fig. 1). The mass is located at the left lower third of her neck below the sternocleidomastoid muscle. It is size is approximately 5x3 cm.

Figure 1
Figure 1: The patient before(A) and after(B) the valsalva maneuver

In her digital substraction angiography examination, there were fusiform dilatation and irregularities in left transverse sinus and transversosigmoid junction level. Filling defect seen in sigmoid sinus, jugular bulb and internal jugular vein. Cervical MRI and MRI angiography shows aneurysmatic dilatation in left transverse sinus and left internal jugular vein (Fig 2). On CT examination, a bony erosion starting from the left squamous part of the occipital bone and continuing to the occipitomastoid junction was noted and thought to be caused by the aneurysm (Fig 3).

Figure 2
Figure 2: Cervical MRI Angiography(A) demonstrating the left internal jugular vein aneurysm and the Digital Substraction Angiography (B) demonstrating the fusiform dilatation at the left transverse sinus and the transversosigmoid junction level.
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Figure 3
Figure 3: Neck CT(A) demonstrating the left internal jugular vein aneurysm and the cranial CT(B) demonstrating the left occipital bone erosion.

Since the patient has no symptom except appearance and the neck mass appears only in Valsalva conditions and surgery will have high morbidity, the patient taken into yearly follow-up visits.

DISCUSSION

Venous aneurysms especially in the neck are very rare conditions. In the literature Harris first described a case of congenital venous cyst in 1928. Since then there has been few reported cases. Most of the IJV aneurysms are located at the left side and have a fusiform morphology.

The differential diagnosis of non-pulsatile neck masses include thyroglossal duct cysts, cystic hygroma, branchial cleft cyst, laryngocele, pharyngocele, dermoid cyst, cervical adenitis, thyroid mass, AVM, and cystic degeneration of tumors. Especially diagnosis of venous aneurysms should be suspected when the mass enlarges its size with increased intrathoracic pressure. Etiology is not clear. It can be traumatic, inflammatory or congenital.

Diagnosis; color duplex USG, dynamic MRI, and venography. Mostly diagnosis is clear by USG.

Pathology; all three layers of normal vein wall are present in venous aneurysms. But elastic and muscular layer thinning may be seen. Thrombus may or may not be present.

This is the first case in the literature that have cranial bone erosion, transverse sinus and IJV aneurysm combination.

There has been no report of rupture or thromboembolic complication of IJV aneurysm so only indication for surgery is cosmetic reasons.

In our case also we preferred clinical follow-up.

References

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