HORNER SYNDROME SECONDARY TO A TRAUMATIC INTERNAL CAROTID ARTERY DISSECTION

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Background:

Only 4% of the **dissections of the internal carotid artery** (DCAI) are of **traumatic origin**. These patients present a wide spectrum of symptoms, highlighting the ipsilateral Horner syndrome. This great clinical variability together with its serious complications make it an **easily underdiagnosed and potentially lethal** pathology.

Case Report:

Our patient is a 26-year-old male who suffers a high energy traffic accident. He is transferred with an ambulance to the intensive care unit of the reference hospital.

Upon arrival it is stable from an hemodynamic and respiratory point of view. Neurologically it is conscious but disoriented in time and space, it presents anisocoric and reactive pupils. He reports loss of visual acuity and diplopia. He is diagnosed with a left paralysis of the sixth cranial nerve and left miosis, which worsens with light, reversing the anisocoria with the Lopimax test. It is oriented as a **left Horner syndrome**.

Magnetic resonance angiography shows images of "intimal flap" with flow on both sides of the left internal carotid artery, at C1 level, compatible with **carotid dissection**.

Given the small size, it doesn't require intravascular stent placement. Blood thinning treatment is started. The patient is discharged after the resolution of his symptoms.

Conclusions:

The DCAI should be considered in young people with symptoms of cerebral ischemia, especially if they have suffered a traumatism. The therapeutic plan (medical vs endovascular) must be individualized according to the location, the clinic and the presence of pseudoaneurysms. It is necessary to establish a protocol for **early diagnosis** to avoid complications and **minimize** long-term **morbidity and mortality**.

Bibliography:

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- **Ipsilateral Horner syndrome**
- **Ipsilateral Pain**
- **Ischemic symptoms of the carotid territory**