2. Diagnostic Cerebral Angiography

Catheter angiography is still considered the gold standard for imaging cerebral vasculature. Diagnostic angiography is also typically done as the first step during neurointerventional procedures. Mastery of diagnostic angiography is a prerequisite for neurointerventional training. Training standards formulated by the American Society of Interventional and Therapeutic Neuroradiology (ASITN), the Joint Section of Cerebrovascular Neurosurgery, and the American Society of Neuroradiology (ASNR) recommend the performance of at least 100 diagnostic angiograms before entering neuroendovascular training. This handbook authors’ preference, however, is for a neurointerventionalist-in-training to perform at least 250 diagnostic cerebral angiograms prior to becoming the lead operator in neurointerventional cases.

2.1. Indications

1. Diagnosis of primary neurovascular disease (e.g., intracranial aneurysms, arteriovenous malformations, dural arteriovenous fistulas, atherosclerotic stenosis, vasculopathy, cerebral vasospasm, acute ischemic stroke)
2. Planning for neurointerventional procedures
3. Intra-operative assistance with aneurysm surgery
4. Follow-up imaging after treatment (e.g., after aneurysm coiling or clipping, treatment of arteriovenous fistulas)

2.2. A Brief History of Cerebral Angiography

The first report of X-ray angiography of blood vessels was in 1896. In Vienna, E. Haschek and O.T. Lindenthal obtained x-rays of blood vessels by injecting a mixture of petroleum, quicklime, and mercuric sulfide into the hand of a cadaver. António de Egas Moniz, a Portuguese neurologist, is credited with the introduction of cerebral angiography. Moniz was interested in developing “arterial encephalography” as a means to localize brain tumors. He obtained cerebral angiograms in cadavers using a solution of strontium bromide and sodium iodide. These early studies demonstrated universal branching patterns among the intracranial arteries, which were contrary to popular theories based on cadaver dissection. After studies in dogs and monkeys, Moniz and his pupil Almeida Lima, performed the first angiogram on living human patients in 1927. The initial attempts were done using percutaneous injections of strontium bromide failed to show any opacified vessels. In later attempts, cervical internal carotid artery was surgically exposed and temporarily occluded with a ligature while a total of 5 mL of a solution of 25% sodium iodide was injected into the vessel. Flow was restored in the artery while simultaneously obtaining an X-ray. After the ninth attempt, successful visualization of the vessels was obtained. Moniz reportedly declared: “Nous avons realise notre desideratum.” (Very loosely translated: “Now that’s what I needed.”) Although no complications were noted during the procedure, one patient died 2 days later in status epilepticus. Moniz went on to obtain successful angiograms in other patients with epilepsy, brain tumors, and postencephalitic Parkinsonism. The first cerebral venogram was accomplished in 1931 when an inadvertent delay in photographing an angiographic plate led to an image of the venous angiographic phase, which Moniz termed a “cerebral phlebogram.” The technique became fully developed in the 1930s. By then, cerebral angiography involved direct percutaneous puncture of the carotid artery and injection of iodinated organic contrast media. Despite a flurry of publications about cerebral...
angiography over the ensuing decade, many by Moniz himself, ventriculography and encephalography remained more popular as methods to image intracranial pathology. Moniz was awarded the Nobel Prize in Physiology and Medicine in 1949 for his work on frontal leukotomy for psychiatric disorders, which, unlike cerebral angiography, gained early and widespread acceptance by the medical community. The popularity of cerebral angiography did rise significantly by the 1950s, becoming the premier method to image the intracranial space. The neurosurgeon Gazi Yasargil performed some 10,000 angiograms between 1953 and 1964.

Direct percutaneous puncture of the cervical carotid artery remained the primary technique for cerebral angiography in the 1950s and 1960s. Direct puncture of the vertebral artery was reported in 1956; the posterior circulation was also imaged by puncture of the right brachial artery and retrograde injection of the contrast into the vertebral artery. The movie The Exorcist (1973) featured a graphic (and realistic) depiction of a direct carotid stick. The transition from direct puncture of the cervical vessels to transfemoral artery arteriography began in the late 1960s and became widespread in the 1970s.

The introduction of computed tomography (CT) in the early 1970s sharply reduced the demand for diagnostic angiography, although the field continued to develop because of the advent of interventional cardiology and other interventional fields. Metrizamide, introduced in the 1970s, was the first nonionic isosmolar iodinated contrast medium. Nonionic contrast media improved the safety and comfort of angiographic procedures considerably.

Digital subtraction angiography (DSA) was introduced in the 1980s as a method for intravenous injection of contrast for imaging the arterial system, as the contrast in the arterial system following intravenous injection was too dilute to be imaged with standard X-rays. Over the ensuing decade, the spatial resolution of DSA imaging improved to the extent that it began to rival the resolution of unsubtracted X-ray images. Further technical refinements in recent years include rotational angiography, 3D angiography, and flat panel detectors for imaging.

Informed consent prior to an angiogram should include an estimate of the risk of complications.

### Neurological Complications

Neurological complications in cerebral angiography are most commonly cerebral ischemic events that occur as a result of thromboembolism or air emboli from catheters and wires. Other causes include disruption of atherosclerotic plaques and vessel dissection. Less common neurological complications include transient cortical blindness and amnesia.

In a prospective analysis of 2,899 diagnostic cerebral angiograms, the largest recent series published to date, Willinsky and colleagues reported an overall rate of neurological complications of 1.3%. Of these, 0.9% were transient or reversible,
0.5% were permanent. The Asymptomatic Carotid Atherosclerosis Study (ACAS) reported an often quoted neurological complication rate of 1.2% with angiography.¹⁹

The risk of complications appears to be related to the underlying disease process. Patients with atherosclerotic carotid disease have been reported to be at elevated risk of neurological complications with cerebral angiography.²⁰ Other risk factors for neurological complications include a recent cerebral ischemic event,²¹,²² advanced age,¹⁸,²⁰ a long angiography procedure time,²⁰,²³,²⁴ and a diagnosis of hypertension,²⁴ diabetes,²⁴ or renal insufficiency.²⁵

The risk of neurological complications in patients with subarachnoid hemorrhage, intracranial aneurysms, and arteriovenous malformations was found to be relatively low in a meta-analysis of prospective studies of angiography.²² For these patients, the overall rate of neurological complications was 0.8%, and the rate of permanent neurological complications was 0.07%. The Joint Standards of Practice Task Force of the Society of Interventional Radiology, the American Society of Interventional and Therapeutic Neuroradiology, and the American Society of Neuroradiology reviewed the complications reported in clinical series and produced guidelines for expected complication rates in neuroangiography (Table 2.1).²⁶ The figures in these guidelines can be quoted to patients during informed consent.

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### Table 2.1 Quality improvement guidelines for adult diagnostic neuroangiography

<table>
<thead>
<tr>
<th>Neurological complications</th>
<th>Suggested complication – specific threshold (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversible neurologic deficit/ Permanent neurologic deficit</td>
<td>2.5/1</td>
</tr>
<tr>
<td>Non-neurologic complications</td>
<td>0.2</td>
</tr>
<tr>
<td>Renal failure/ Arterial occlusion requiring surgical thrombectomy or thrombolysis</td>
<td>0.2</td>
</tr>
<tr>
<td>Arteriovenous fistula/pseudoaneurysm</td>
<td>0.2</td>
</tr>
<tr>
<td>Hematoma requiring transfusion or surgical evacuation</td>
<td>0.5</td>
</tr>
</tbody>
</table>

| All major complications | 2 |

---

Nonneurological Complications

Nonneurological complications of cerebral angiography via the femoral artery include groin and retroperitoneal hematoma, allergic reactions, femoral artery pseudoaneurysm, thromboembolism of the lower extremity, nephropathy, and pulmonary embolism.²⁷ In a review of 2,899 cerebral angiograms, hematomas occurred in 0.4% of procedures, allergic cutaneous reactions occurred in 0.1%, and a pseudoaneurysm occurred after one (0.03%) procedure.¹⁸

### 2.4. Cerebral Angiography: Basic Concepts

#### Preprocedure Evaluation

1. A brief neurological exam must be conducted to establish a baseline, should a neurologic change occur during or after the procedure.
2. The patient should be asked if he or she has had a history of iodinated contrast reactions.
3. The femoral pulse, as well as the dorsalis pedis and posterior tibialis pulses, should be examined.
4. Blood work, including a serum creatinine level and coagulation parameters, should be reviewed.

Pre-angiogram Orders
1. NPO except medications for 6 h prior to the procedure.
2. Place 1 peripheral IV (2 if an intervention is anticipated).
3. Place foley catheter (only if an intervention is anticipated).

Contrast Agents
Nonionic contrast agents are safer and less allergenic than ionic preparations. Iohexol (Omnipaque®, GE Healthcare, Princeton, NJ), a low osmolality, nonionic contrast agent, is relatively inexpensive and probably the most commonly used agent in cerebral angiography.
1. Diagnostic angiogram: Omnipaque®, 300 mg I/mL
2. Neurointerventional procedure: Omnipaque®, 240 mg I/mL
Patients with normal renal function can tolerate as much as 400–800 mL of Omnipaque®, 300 mg I/mL without adverse effects.

Femoral Artery Sheath (vs. No Sheath)
Trans-femoral angiography can be done with or without a sheath.

Sheath
1. Allows for the rapid exchange of catheters and less potential for trauma to the arteriotomy site.
2. Shown in a randomized trial to lessen the frequency of intraprocedural bleeding at the puncture site, and to ease catheter manipulation.
3. Short sheath (10–13-cm arterial sheath) is used most commonly.
4. Longer sheath (25 cm) is useful when iliofemoral artery tortuosity or atherosclerosis might impair catheter navigation.
5. Technique: A 5F sheath (Check-Flo® Performer® Introducer set; Cook, Bloomington, IN) is slowly and continuously perfused with heparinized saline (10,000 U heparin per liter of saline) under arterial pressure.
6. Sheaths come in sizes 4F up to 10F or larger. The size refers to the inner diameter. The outer diameter is 1.5–2.0F larger than the stated size.

No Sheath
1. Slightly smaller arteriotomy and permitting earlier ambulation.
2. Use a 4F, 5F, or 3.3F catheter.
3. Technique: After the Potts needle enters the femoral artery, a 145 cm 0.035 in. J-tipped wire (for most 4F catheters) or a 145 cm 0.038 in. J-tipped wire (for most 5F catheters) is introduced instead of a short J-wire. The Potts needle is then exchanged for an appropriately sized dilator, which is then exchanged for the diagnostic catheter.
4. Note: If a 4F or smaller catheter is going to be used without a sheath, use an appropriately sized micropuncture set, because a standard 18 gauge Potts needle creates an arteriotomy larger than the catheter, resulting in bleeding around the catheter.
Sedation/Analgesia

1. Midazolam (Versed®) 1–2 mg IV for sedation; lasts approximately 2 h
2. Fentanyl (Sublimaze®) 25–50 μg IV for analgesia; lasts 20–30 min

The use of sedation should be minimized, as over-sedation makes it hard to detect subtle neurological changes during the procedure. Paradoxical agitation has been reported in up to 10.2% of patients, particularly elderly patients and patients with a history of alcohol abuse or psychological problems. Flumazenil (Romazicon®) 0.2–0.3 mg IV can reverse this effect.

Suggested Wires and Catheters
for Diagnostic Cerebral Angiography

Hydrophilic Wires

1. The 0.035 in. angled Glidewire® (Terumo Medical, Somerset, NJ) is soft, flexible, and steerable.
2. The 0.038 in. angled Glidewire® (Terumo Medical, Somerset, NJ) is slightly stiffer than the 0.035 in., making it helpful when added wire support is needed.
3. Extra-stiff versions of these wires are available for even more support, but they should be used with extreme caution because of the tendency of the tip to dissect vessels.

Catheters

Many catheters are suitable for cerebral angiography (Fig. 2.1). As a general rule, use 100 cm long catheters that have a curve that allows selection of the vessels from the arch. Simpler curves (e.g. Berenstein curve) are adaptable to many anatomic situations and are most appropriate for young patients with straighter vessels.

Fig. 2.1 Recommended diagnostic catheters: 5F Angled Taper, Good all-purpose diagnostic catheter. 4 or 5F Vertebral, Good all-purpose diagnostic catheter, slightly stiffer than the Angled Taper but similar in shape. 4 or 5F Simmons 1, Spinal angiography. 4 or 5F Simmons 2 or 3, Left common carotid artery; bovine configuration; tortuous aortic arch; patient’s age > 50. 5F CK-1 (aka HN-5), Left common carotid or right vertebral artery. 5F H1 (aka Headhunter), Right subclavian artery; right vertebral artery. 4 or 5F Newton, Tortuous anatomy, patients > 65.
More complicated curves (e.g. Simmons curve) help deal with more difficult aortic arch anatomy.

<table>
<thead>
<tr>
<th>Measurement systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needles:</strong> Gauge, which is a measurement system too obscure for the human mind to grasp. The larger the gauge, the smaller the needle</td>
</tr>
<tr>
<td><strong>Catheters:</strong> French (F), defined as the outer diameter of a catheter measured as a multiple of thirds of a millimeter (French number/3 = outer diameter in mm)</td>
</tr>
<tr>
<td><strong>Wires:</strong> Measured in thousandths of an inch. (a 0.035 wire is 0.035 in. thick)</td>
</tr>
</tbody>
</table>

**Global Gem! The French System**
The French system comes from Joseph-Frédéric-Benoît Charrière, a nineteenth-century Parisian maker of surgical instruments. A urinary catheter 5 mm in diameter was made by rolling a 15 mm wide strip of rubber into a tube. The diameter (circumference/π, or ~15 mm/3.14) was roughly equal to three times the width of the strip plus the glue to hold it together. The incomprehensible gauge system was developed by the British.

**2.5. Catheter Navigation**

Diagnostic catheters should usually be advanced over a hydrophilic wire. The wire keeps the catheter tip from rubbing against the wall of the vessel and causing a dissection. When advancing the wire and catheter toward the aortic arch from the femoral artery, the tip of the wire should be followed by direct fluoroscopic visualization. The catheter/wire assembly should never be advanced with <8–10 cm of wire extending from the tip, as a short length of leading wire can act as a spear and cause injury to the intima. A catheter/wire assembly with only a few cm of wire sticking out can resemble a Roman short sword (Fig. 2.2).

**2.6. Roadmapping**

Roadmapping should be used when engaging the vertebral arteries, and the internal and external carotid arteries. Roadmapping is essential during intracranial navigation. In some angiography suites, a “false roadmap” can be created using a regular digital subtraction angiogram; a frame from an angiographic run is selected, then inverted (i.e., vessels are turned white against a black background). This technique conserves contrast and reduces radiation exposure.

**2.7. Double Flushing**

Double flushing consists of aspiration of the contents of the catheter with one 10-mL syringe of heparinized saline, followed by partial aspiration and irrigation with a second syringe of saline. This maneuver clears clots and air bubbles from the catheter, and should be done every time a wire is removed from the catheter, prior to the injection of contrast. Meticulous attention to detail is required to prevent blood from sitting in the catheter lumen, where it can coagulate into potential emboli. Any air bubbles in the system can also occlude small vessels if injected intravascularly.
2.8. Continuous Saline Infusion

A three-way stopcock or manifold can be used to provide a heparinized saline drip through the catheter. This continuous drip is particularly useful if there is any delay between injections of contrast, because it keeps the catheter lumen free of blood products. Careful double flushing is still required if a wire is inserted and removed or if any blood is present in the lumen. Use of stopcocks and continuous infusion is mandatory for any therapeutic intervention.

2.9. Hand Injection

A 10-mL syringe containing contrast should be attached to the catheter, and the syringe should be snapped with the middle finger several times to release bubbles stuck to the inside surface. The syringe should be held in a vertical position, with the plunger directed upward, to allow bubbles to rise away from the catheter (Fig. 2.3). For larger
vessels, like the common carotid artery, the plunger on the syringe can be depressed with
the palm of the hand in order to generate enough force; for smaller vessels, like the verte-
bral arteries, thumb-depression of the plunger is sufficient. An adequate angiographic run
can be done with a single swift injection of 4–6 mL of contrast (70%) mixed with saline
(30%). The patient should be instructed to stop breathing (“Don’t move, don’t breath, don’t
swallow”) for several seconds during the angiogram, then told to start breathing again.

A Poetic Interlude

Bubbles
I love ‘em in my lager.
I love ‘em in my stout.
But when they get inside my head
I want to get them out!
I hate them in carotids.
I hate them in the “verts.”
They end up doing something bad.
Oh yes, it really hurts!
The small ones make me stupid.
The big ones make me dead.
‘Cause when they get inside me
They dance around my head!
The little doctors search and search
And shake out all they find.
The ones they missed
(It makes me pissed!)
Will make me lose my mind!
They find them in my saline.
They find them everywhere!
And superficial temporal ones
Will make me lose my hair!

Prevention of Cerebral Air Emboli

- Use meticulous technique for flushing and contrast injections (see above).
- Whenever possible, flush the catheter in the descending aorta to keep bub-
  bles away from the cerebral circulation.
2.10. Mechanical Injection

A power contrast injector is necessary for aortic arch angiograms, and some operators prefer to use an injector routinely for other vessels as well. Mechanical injection can lower radiation exposure to the operator’s hands and body. The pressure (pounds per square inch, psi) and flow rate during the injection should not exceed the rated pressure or flow rate of the catheter. Likewise, if a stopcock is used, the psi during injection should not exceed the rated pressure and flow rate. Common power injector settings for selective catheter digital subtraction diagnostic angiograms using a 5F catheter are listed in Table 2.2. The term “rate rise” refers to a setting on the mechanical injector that causes it to gradually increase the rate of contrast flow during the injection, to prevent the catheter tip from being kicked out of the vessel it is in. Rate rise is defined as the time required for a syringe to fill, allowing it to sit for a few minutes before injection will allow bubbles to come out of suspension and become visible.

Management of Cerebral Air Emboli

- Prevention is best, but if air emboli are suspected, urgent treatment is required to prevent stroke caused by occlusion of flow in vessels due to the surface tension produced by the interface between air and blood.
- If the gas embolus is large enough to be detected fluoroscopically, and the vessel is easily accessible, a microcatheter may be used to aspirate the gas embolus and flush the vessel with heparinized saline to break up the remaining bubbles.
- Quick and readily available (though unproven) methods include the use of transcranial Doppler (to agitate and break up bubbles), heparinization (to prevent clot from forming in vessels stagnating from the air), and administration of oxygen and induction of hypertension (as in vasospasm therapy).
- If available, hyperbaric oxygen chambers have been shown (anecdotally and in small series) to result in good outcomes. One report indicated a benefit even after a delay in initiated hyperbaric therapy. A larger series showed 67% good outcome when hyperbaric treatment was started within 6 h after the onset of symptoms, versus only 35% good outcomes when treatment began later.
- Induction of retrograde cerebral flow by infusing arterial blood under pressure in the jugular vein has been shown to limit ischemic damage to the brain.
- When in doubt, a variety of methods can be used simultaneously, including hyperbaric oxygen plus retrograde cerebral flow plus induction of barbiturate coma to attempt to protect the brain.
- The most important thing is to recognize that air emboli have occurred and then use whatever treatment modalities that are available.

Table 2.2 Standard power injector settings

<table>
<thead>
<tr>
<th>Vessel</th>
<th>Power injector settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aortic arch</td>
<td>20 mL/s; total of 25 mL</td>
</tr>
<tr>
<td>Common carotid artery</td>
<td>8 mL/s; total of 12 mL</td>
</tr>
<tr>
<td>Subclavian artery</td>
<td>6 mL/s; total of 15 mL</td>
</tr>
<tr>
<td>Internal carotid artery</td>
<td>6 mL/s; total of 8 mL</td>
</tr>
<tr>
<td>External carotid artery</td>
<td>3 mL/s; total of 6 mL</td>
</tr>
<tr>
<td>Vertebral artery</td>
<td>6 mL/s; total of 8 mL</td>
</tr>
</tbody>
</table>

For digital subtraction angiography using a 5F catheter
during the injection to reach the maximum flow rate. If the vessel is smaller than average, occluded, or if the catheter is in an unstable position within the vessel, a rate rise of 0.3–0.5 s should be used. Power injector settings are different (longer) when a 3D angiogram is done; typical settings for 3D images are 3 mL/s, total of 18 mL or 4 mL/s; total of 24 mL.

### 2.11. Vessel Selection

A cerebral angiogram should begin with the vessel of interest first, so that the most important vessels can be imaged in case problems with the equipment or the patient prevent completion of the entire angiogram. Following catheterization of the vessel of interest, it is usually easiest to navigate from right to left (i.e., the right vertebral artery, followed by the right common carotid artery, etc.).

#### Angiographic Images and Standard Views

1) Biplane angiography is the standard of care for cerebral angiography. It allows for orthogonal images to be simultaneously obtained with a single contrast injection, limiting the time and amount of contrast needed to adequately visualize the cerebral vasculature. Monoplanar cerebral angiography is acceptable only when biplane equipment is not available; the use of monoplane imaging is limited by its inability to perform automatic optical calibration and to image from orthogonal views simultaneously.

2) When viewing the angiographic images, the contrast and brightness of the image should be adjusted so that vessels are semitransparent; this can allow visualization of aneurysms, branches, or filling defects (e.g., intraluminal thrombus), which may otherwise not be visible.

3) Other imaging features worthy of attention during the performance of a cerebral angiogram:
   a) Vessel contour and size (“angioarchitecture”)
   b) Contrast flow patterns
   c) Presence or absence of a vascular blush
   d) Venous phase (i.e., do not forget to examine the venous phase)
   e) Bony anatomy

Standard skull views are illustrated in Fig. 2.4. The “standard” postero-anterior (PA) projection angulates the X-ray tube usually 15–20° in a cranial direction to superimpose the roof of the orbits and top of the petrous ridges. This has been the traditional angiographic view for the carotid injections since it gives good overview of the arterial structures and allows a standard projection regardless of how much the patient’s head is angulated on the table. A straight PA view may place the petrous ridges at variable relationships with the roof of the orbits, with resultant variable appearance of the intracranial vessels depending on how the patient is positioned. This view is frequently used since it requires no angulation of the X-ray C-arm. The Caldwell projection is usually done with approximately 25° caudal angulation of the X-ray tube. It aligns the petrous ridges with the bottom third of the orbits to provide a view of orbital and supratentorial structures unobstructed by the petrous ridges. The Towne’s view, with 30–40° cranial angulation aligns the petrous ridges below the superior rim of the orbits and is the standard PA view for imaging the posterior fossa, since it elongates the posterior cerebral arteries. The patient can be asked to tuck his or her chin to the chest to optimize the cranial angulation. The Water’s view is inclined 45° caudal and positions the petrous ridges some distance below the orbits; this is a good view for imaging the maxillary sinuses, and is an excellent view to show the full length of the basilar artery. Sub-mentovertex (aka basal or axial) view requires very steep caudal angulation such that the image intensifier is often touching the patient’s chest. It helps to tilt the patient’s head back to obtain this view. This is a very useful view for the middle cerebral bifurcation and Acomm. Lateral views should line up the floor of the anterior fossa and external auditory canals bilaterally to ensure a true lateral view.

The Haughton projection is a lateral view and is helpful for imaging the carotid siphon and the middle cerebral bifurcation (Fig. 2.5). The patient’s head is inclined...
Fig. 2.4 Standard PA and lateral projections. (a) Standard PA. The petrous bones line up with the upper margin of the orbits. Elderly angiographers prefer this traditional view for intracranial anterior circulation angiography. (b) Straight PA. No cranial, or caudal angulation is done. In this case, the petrous bones are at the lower edge of the orbits. Younger angiographers prefer this view to the "standard PA" view. (c) Caldwell. 25° caudal angulation. The petrous bones are about one third of the way up the orbits. (d) Towne. 35° cranial angulation. The foramen magnum (arrow) can be seen through the calvarium.
away from the side of the injected carotid artery; this view opens up the carotid siphon. Specific views commonly used to optimize display of certain anatomic structures are listed in Table 2.3. All of these views should be done with tight collimation of the X-ray source over the area of interest to limit scatter radiation and with the imaging detector as close to the head as possible to minimize image degradation from geometric magnification.

**Pearl**

Mnemonic for remembering the relative positions of the standard PA projections: The Water(s) runs beneath the Town(e). Caldwell is in between.
Frame Rates for Digital Subtraction Angiography

Most cerebral angiography can be done with 3–5 fps. Higher rates (e.g., 8–20 fps) are useful for imaging arteriovenous malformations and other high-flow lesions. Usually, a variable frame rate may be used to limit radiation dose, since a higher frame rate (3/s) is needed in the arterial phase, whereas a lower rate (0.5–1/s) can be used in the venous phase. For standard cerebral arteriography, a 10–12 s imaging sequence allows for visualization of arterial, capillary, and venous phases.

Calibration and Measurement

Biplanar angiography units are capable of auto-calibration by analysis of simultaneous orthogonal images. Monoplanar angiography requires placement of a marker on or in the patient. A United States dime is 18 mm in diameter and can be taped to the patient’s face or head; however a marker on the surface of the patient’s body can be inaccurate in the measurement of internal structures because of magnification. Magnification error can lead to errors in linear measurement of up to 13%. Markers on intravascular catheters and wires, placed close to the angiographic target, are more accurate. The ATW™ Marker Wire (Cordis, Miami Lakes, FL) has radio-opaque markers that are 1-mm wide and spaced 10 mm apart. “Two-tipped” microcatheters for detachable coil deployment have markers that are spaced 3 cm apart. To maximize accuracy, the calibration marker and the structure being measured should be as close to the center of the image as possible to minimize the effect of X-ray beam divergence.

Fig. 2.5 Haughton view for imaging the left carotid siphon and MCA candelabra. The carotid siphon and MCA candelabra can often be seen most clearly by positioning the lateral arc as if the patient’s head is tilted away from the side of injection. A mnemonic to remember this is: “The X-ray tube should touch the shoulder on the side of interest.”
Table 2.3  Standard views

<table>
<thead>
<tr>
<th>Target</th>
<th>Optimal views</th>
<th>Additional views/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carotid bifurcation</td>
<td>Standard PA</td>
<td>Ipsilateral oblique</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td></td>
</tr>
<tr>
<td>Anterior intracranial circulation</td>
<td>Standard PA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td></td>
</tr>
<tr>
<td>ICA cavernous segment</td>
<td>Caldwell</td>
<td>Haughton</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td></td>
</tr>
<tr>
<td>ICA ophthalmic segment</td>
<td>Caldwell</td>
<td>Transorbital oblique</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td></td>
</tr>
<tr>
<td>Posterior communicating artery aneurysms</td>
<td>Haughton</td>
<td>Lateral</td>
</tr>
<tr>
<td></td>
<td>Transorbital oblique</td>
<td></td>
</tr>
<tr>
<td>ICA bifurcation</td>
<td>Transorbital oblique</td>
<td>Sometimes submentovertex</td>
</tr>
<tr>
<td>Anterior communicating artery aneurysms</td>
<td>Transorbital oblique</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submentovertex</td>
<td></td>
</tr>
<tr>
<td>Middle cerebral artery aneurysms</td>
<td>Transorbital oblique</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Submentovertex</td>
<td></td>
</tr>
<tr>
<td>Middle cerebral artery candelabra</td>
<td>Lateral with Haughton</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waters with oblique</td>
<td></td>
</tr>
<tr>
<td>Vertebral artery origin</td>
<td>Towne</td>
<td>The vertebral artery arises from the posterior aspect of the subclavian artery</td>
</tr>
<tr>
<td>Posterior circulation</td>
<td>Water</td>
<td>Ipsilateral oblique</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td></td>
</tr>
<tr>
<td>Basilar artery</td>
<td>Water</td>
<td>Ipsilateral oblique</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td>Water will “elongate” the basilar artery trunk</td>
</tr>
<tr>
<td>PCA, SCA, AICA, PICA</td>
<td>Towne</td>
<td>Towne elongates PCA. Ipsilateral oblique helps</td>
</tr>
<tr>
<td></td>
<td>Lateral</td>
<td>Caveat: Paired vessels overlap</td>
</tr>
<tr>
<td>Basilar apex aneurysms</td>
<td>Water</td>
<td>Ipsilateral oblique</td>
</tr>
<tr>
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<td>Lateral</td>
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Angiographic positions for common anatomical targets. ICA internal carotid artery, PCA posterior cerebral artery, SCA superior cerebellar artery, AICA anterior inferior cerebellar artery, PICA posterior inferior cerebellar artery

2.12. Procedures

Femoral Artery Puncture

1) Prepare and drape the groin area.
2) Palpate the femoral pulse at the inguinal crease, and infiltrate local anesthesia (2% lidocaine), first by raising a wheal and then injecting deeply toward the artery. **Caveat: Do not inject anesthesia too laterally: Injecting directly in the nerve can cause a femoral neuropathy that persists for hours.**
3) Make a 5 mm incision parallel to the inguinal crease with an 11-blade scalpel.
4) Insert a Potts needle with the bevel facing upward. Advance it at a 45° angle to the skin, pointing toward the patient’s opposite shoulder.
5) Attempt a single-wall puncture especially if heparin or antiplatelet agents are used. Do it by looking for blood return from the hollow stylet of the Potts needle. Advance the needle 1–2 mm after the first blood return since the stylet protrudes that far beyond the tip of the needle.
6) Make a two-wall puncture by advancing the needle through-and-through both vessel walls, remove the stylet, and slowly withdraw the needle until pulsatile blood return is obtained.
7) When bright red, pulsatile arterial blood is encountered, gently advance a J-wire through the needle for 8–10 cm.
8) Exchange the needle for a 5F sheath, and secured it with a silk stitch.

**Pearls**
If the artery is difficult to locate, try the following tricks:
- After inserting the Potts needle, let go of it. If the needle pulsates medially or laterally, the artery is usually located to the side that the needle is pulsating toward.
- Fluoroscopic bony landmarks. On PA fluoroscopy, the femoral artery is located 1 cm medial to the center of the femoral head (Fig. 2.6).

**Fig. 2.6** Fluoroscopic landmarks for femoral artery puncture. The femoral artery is located approximately 1 cm medial to the center of the femoral head. The X indicates the center of the femoral head.

- Use a micropuncture set (see instructions below). An atherosclerotic femoral artery can be heavily calcified and deflect larger needles; a smaller needle can sometimes be helpful.
- Use a needle with a Doppler ultrasound stylet (Smart-needle®, Vascular Solutions, Minneapolis, MN) (20 gauge or smaller) to allow puncture of a non-palpable vessel.
- Try the opposite groin or the upper extremity approach.
- Puncturing vascular grafts can be difficult due to extensive scar tissue. This may require use of a stiff Amplatz guidewire, use of dilators one size larger than the inserted catheter or sheath, and certain soft catheters should not be used because they may fracture. In general, it is best to use a sheath in Gore Tex® grafts (W.L. Gore, Flagstaff, AZ).
Micropuncture Technique
1. Obtain micropuncture set appropriately sized (4 or 5F).
2. Insert the 21 gauge needle in same fashion as a Potts needle.
3. Insert 0.018 in. microwire.
4. Exchange 21 gauge needle for the dilator.
5. Exchange dilator for the sheath.

The Buffalo Scale for Procedural Blood Loss Estimation*
A Novel Method
A Number One: We’re having fun.
A Number Two: It’s on the shoe.
A Number Three: It’s on your knee.
A Number Four: It’s on the floor.
A Number Five: It’s in the sky.
A Number Six: Can’t be fixed.
A Number Seven: Patient’s going to heaven.
A Number Eight: Call for a crate.
*Developed and validated during the fellowship of one this handbook’s authors.

Aortic Arch Imaging
1) Guide a 4F or 5F pigtail catheter over a hydrophilic wire into the ascending part of the aortic arch.
2) Place the image intensifier (II) on low magnification and rotate 30° to the left.
3) The patient’s head is thus rotated to the left, so that his or her face is facing the II (this position will permit visualization of the cervical vessels).
4) Use a power injector to administer contrast.
5) Supplement standard left anterior oblique (LAO) view with a lateral view by rotating the II 30° to the right.

Carotid Artery Catheterization
1) Advance an angled diagnostic catheter over a hydrophilic wire over the aortic arch to a position proximal to the innominate artery.
2) Bring back the wire into the catheter, and gently pull the catheter back, with the tip of the catheter facing superiorly, until the innominate artery is engaged. Advance the wire superiorly in the right common carotid artery, followed by the catheter.
3) To engage the left common carotid artery, pull the catheter gently and slowly out of the innominate artery, with the wire inside the catheter and the tip facing to the patient’s left, until the catheter “clicks” into the left common carotid. Then advance the wire superiorly, followed by the catheter.
4) For older patients (>50 years), and those with a bovine arch configuration, the Simmons II catheter is helpful for accessing the left common carotid.
5) If selective internal carotid artery catheterization is planned, first do angiography of the cervical carotid system to check for internal carotid artery stenosis in any patient at risk of atherosclerosis. Catheterization of the internal carotid artery should be done under roadmap guidance.
6) Turning the patient’s head away from the carotid being catheterized may allow the wire and/or catheter to enter the vessel more easily.
7) Once the common carotid is catheterized, turning the head away from the side being catheterized facilitates internal carotid catheterization, and turning toward the ipsilateral side facilitates external carotid catheterization.
8) When the wire or catheter does not advance easily into the vessel of interest, ask the patient to cough. It often bounces the catheter into position.
Vertebral Artery Catheterization

1) Place an angled diagnostic catheter over a hydrophilic wire and into the subclavian artery. Intermittent “puffing” of contrast will allow identification of the vertebral artery origin.

2) Make a road map and pass the wire into the vertebral artery until the tip of the wire is in the upper third of the cervical portion of the vessel. Placing the wire relatively high in the vertebral artery provides adequate purchase for advancement of the catheter, will help straighten out any kinks in the artery that may be present near the origin, and will also facilitate smooth passage of the catheter past the entrance of the of artery into the foramen transversarium at C6. The C6 foramen transversarium is where the vertebral artery makes a transition from free-floating to fixed, and is a region at risk for iatrogenic dissection if the catheter is allowed to scrape against the wall of the vessel.

3) Remember that the vertebral artery makes a right angle turn laterally at C2, so be careful not to injure the vessel at that point with the wire.

4) After removal of the wire, and double flushing, do an angiogram with the tip of the catheter in view, to check for dissection of the vessel during catheterization.

5) For patients at risk of atherosclerosis, do an angiogram of the vertebral artery origin prior to accessing the vessel to check for stenosis.

6) Uncommonly, the left vertebral artery arises directly from the aorta, which should be kept in mind when the origin of the vessel cannot be found on the left subclavian artery.

7) When kinks or loops in the vessel prevent catheterization, ask the patient to tilt their head away from the vertebral artery being catheterized. Several options exist for patients in whom vessel tortuosity (usually of the innominate artery) makes catheterization of the vertebral artery difficult.

   1. Do a roadmap with an ipsilateral oblique Towne view; this will show the vertebral artery origin, and separate the vertebral artery from the common carotid artery.
   2. Try a Headhunter catheter. It is well suited for navigation through a tortuous innominate artery.
   3. Other catheters that can be helpful in negotiating a difficult right vertebral artery are the Vertebral catheter and the DAV catheter.
   4. When catheterization of the vertebral artery is not possible because of tortuosity of the great vessels or atherosclerotic stenosis, inflate a blood pressure cuff on the ipsilateral upper extremity and inject 100% contrast into the subclavian artery with a power injector. The inflated cuff will direct flow away from the arm and toward the vertebral artery. Be careful not to place the catheter with its tip in the thyrocervical or costocervical trunks. A large volume contrast injection in these small vessels can be painful, and can cause spinal cord injury in cases where large spinal cord feeders arise from these branches, or even directly from the subclavian artery. If the catheter tip cannot be placed in a stable position in the subclavian artery proximal to the origin of the vertebral artery, place the tip distal to the origin of the vertebral artery.

5) Set the power injector to allow a good injection without kicking the catheter out: 6 mL/s; total of 25 mL, linear rate rise: 0.5 s.

Reconstituting a Simmons 2 Catheter

The Simmons 2 catheter is useful in the catheterization of the left common carotid artery, particularly when there is a bovine configuration, when the aortic arch is tortuous, and in patients aged >50. The catheter can be reconstituted in the left subclavian artery, the aortic arch, or the aortic bifurcation (Figs. 2.7 and 2.8). Reconstitution in the left subclavian or aortic bifurcation is preferred to the aortic arch, to minimize risk of dislodging atherosclerotic plaque material and subsequent embolization into the intracranial circulation.

Remember that the tip of the Simmons catheter advances into the vessel when the catheter is pulled back at the groin and pulls out of the vessel when the catheter is pushed forward at the groin. This effect is the reverse of the behavior of more simple-curved or angled catheters. The Simmons catheter can also be advanced antegrade over a wire, allowing for selective catheterization of the internal or external carotid arteries.
Femoral Artery Puncture Site Management

The “gold standard” for management of the arteriotomy after an angiogram is manual compression.

1. Remove the sheath and apply pressure to the groin 1–2 cm superior to the skin incision.

2. Apply pressure for 15 min: usually 5 min of occlusive pressure, followed by 10 min of lesser pressure.
   (a) For patients on aspirin and/or clopidogrel, a longer time is required, usually 40 min. At the end of the time period, slowly release pressure on the groin.

3. At the end of the time period, release pressure on the groin slowly and apply a pressure dressing.

4. The Chito-seal™ pad (Abbott Laboratories, Abbott Park, IL) and the Syvek® NT Patch (Marine Polymer Technologies, Inc., Danvers, MA) are topical hemostatic agents that can be applied to the incision after sheath removal to accelerate hemostasis.
   (a) In an animal model the Syvek® Patch was found to control bleeding better than Chito-seal™.
   (b) These topical agents cannot be expected to produce the same security of hemostasis as the closure devices described below, especially if the sheath size is greater than 5F.

5. A balloon compression dressing (FemoStop®plus Femoral Compression System, Radi Medical Systems, Wilmington, MA) compresses the site with a balloon, but the balloon must be deflated after 1 h to prevent pressure injury to the skin. The dressing is then left in place and the balloon can be reinflated if oozing from the site occurs.

6. After compression, the patient should remain supine for 5 h, then be allowed to ambulate but remain under nursing observation for one more h prior to discharge.

7. Of note: A study of coronary angiographic procedures showed no difference in vascular complications between 2, 4, or 6 h bedrest after hemostasis, even when using abciximab.

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Fig. 2.7 Reconstituting a Simmons 2 catheter in the left subclavian artery. The catheter is advanced over a hydrophilic wire into the left subclavian artery so that the tip is in the subclavian artery (a), and the primary bend in the catheter (the “elbow”) is in the aortic arch. The wire is then withdrawn until the tip is proximal to the elbow (b), and the catheter is then pushed forward, until the elbow moves into the proximal part of the aortic arch (c), and the tip of the catheter is out of the subclavian artery, directed backward toward the shaft of the catheter.
8. Early mobilization even as early as 1.5 h after hemostasis does not significantly increase the incidence of hematomas but definitely reduces complaints of back pain.84
9. Using topical hemostatics, the patient should generally remain flat in bed for 2 h, and can ambulate in 3 h.

Fig. 2.8 Alternative method for reconstituting a Simmons 2 catheter. The catheter is advanced over a hydrophilic wire so the tip of the catheter is in the ascending aorta (a). The wire is then withdrawn until the wire tip is proximal to the elbow, and the catheter is rotated clockwise as it is simultaneously withdrawn so that the loop is in the descending aorta (b, c). The wire is then advanced swiftly (d), to reconstitute the catheter.
Closure Devices

Percutaneous femoral artery closure devices can allow the patient to ambulate sooner than with compression techniques, and can be helpful when the patient is on antiplatelet or anticoagulant medications. Most closure device instructions recommend puncture site arteriograms (Fig. 2.9) since use of these devices may be contraindicated if a bifurcation or excessive plaque is at the puncture site. When a closure device is used, the patient should remain supine for 1 h. However, there is a greater risk of complications with the use of closure devices. In a meta-analysis to assess the safety of closure devices in patients undergoing percutaneous coronary procedures, an overall analysis favored mechanical compression over closure devices.\textsuperscript{55}

Selected Femoral Artery Closure Devices

1) Perclose\textsuperscript{®} Pro-glide\textsuperscript{™} (Abbott Vascular, Abbott Park, IL, Inc.).
   a) Closure method: A proline stitch is placed in the arteriotomy.
   b) Requires a femoral artery angiogram; the puncture site must be at least 1 cm away from major branches of the vessel, such as the femoral artery bifurcation (Fig. 2.8).
   c) Advantage: The same artery can be re-punctured immediately if necessary.

2) Angio-Seal\textsuperscript{™} (St. Jude Medical, St. Paul, MN).
   a) Closure method: The device creates a mechanical seal by sandwiching the arteriotomy between a bioabsorbable anchor and a collagen sponge, which dissolves within 60–90 days.
b) May be used at femoral artery branch points.

c) If re-puncture of the same femoral artery is necessary within 90 days, then the reentry site should be 1 cm proximal to the previous site.56,57

3) Mynx™ Cadence (AccessClosure, Mountain View, CA).

   a) Closure method: The device places an expanding glycolic sealant over the arteriotomy.
   
   b) In a series of 146 devices deployed in 135 patients, 18% were found to have intravascular Mynx sealant on follow-up vascular imaging, and 11% were found to have pseudoaneurysms.58 Another study comparing Mynx to Angio-Seal found a higher rate of device failure with Mynx.59

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**Post-angiogram Orders**

1) Bed rest with the accessed leg extended, head of bed $\leq 30^\circ$, for 5 h, then out of bed for 1 h. (If a closure device is used, bed rest, with head of bed $\leq 30^\circ$, for 1 h, then out of bed for 1 h).

2) Vital signs: Check on arrival in recovery room, then Q 1 h until discharge. Call physician for SBP <90 mmHg or decrease 25 mmHg; pulse >120.

3) Check the puncture site and distal pulses upon arrival in recovery room, then Q 15 min $\times$ 4, Q 30 min $\times$ 2, then Q 1 h until discharge. Call physician if:
   
   a) Bleeding or hematoma develops at puncture site.
   
   b) Distal pulse is not palpable beyond the puncture site.
   
   c) Extremity is blue or cold.

4) Check puncture site after ambulation.

5) IVF: 0.9N.S. at a maintenance rate until patient is ambulatory.

6) Resume pre-angiogram diet.

7) Resume routine medications.

8) PO fluids 400 mL.

9) D/C IV prior to discharge.

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### 2.13. Special Techniques and Situations

#### Brachial and Radial Artery Puncture

The arteries of the upper extremity are a useful alternative to the femoral artery for both diagnostic cerebral angiography and some neurointerventional procedures. Access via the brachial artery60 or radial artery61 eliminates the risk of retroperitoneal hemorrhage and the need for several hours of bed rest that are associated with femoral artery puncture. In addition, an upper extremity approach can be advantageous when vessel tortuosity makes access to the vertebral artery difficult from a femoral approach. The authors prefer the brachial artery approach to the radial artery approach because an Allen test is not needed for the brachial artery approach and the threat of hand ischemia – and the potential loss of the patient’s dominant hand – is less.

#### Approaches to the Great Vessels from the Arm

The upper extremity approach is nicely suitable for access to the ipsilateral vertebral artery. The common carotid arteries and left subclavian artery can be reached from the right arm by reflecting a 5F Simmons 2 catheter off of the aortic valve (Fig. 2.10).

#### Brachial Artery Access

Position the patient’s upper extremity on an arm board, extending away from the angiography table. The table is rotated about 20° to permit fluoroscopy of the upper extremity. Palpate the brachial artery just proximal to the elbow, then map out the...
vessel with a hand-held Doppler device. Prep the area is prepped and place a sterile “hole drape” over the puncture site. Inject local anesthetic, and use a micropuncture set to place a 4F or 5F sheath in the brachial artery. Connect a heparinized saline pressure bag to the sheath. Do a gentle angiogram immediately after placement of the sheath to rule out a dissection and to confirm that antegrade flow in the artery is preserved after placement of the sheath. If significant vasospasm is present, consider injecting the radial artery cocktail (see below).

**Radial Artery Access**

Prior to the radial artery puncture, an Allen test is necessary to ensure adequate collateral circulation to the hand from the ulnar artery. Place a pulse oximeter on the patient’s thumb, and instruct the patient to repeatedly clench the fist. Compress both the radial artery and the ulnar artery until the pulse oximetry tracing flattens, then take pressure off the ulnar artery. Normal capillary refill time is 5 s or less; a refill time of greater than 10 s is abnormal and an evidence of poor collateral circulation to the hand from the ulnar artery via the palmar arch. In a series of patients undergoing coronary catheterization, an Allen test finding indicating poor collateral circulation was found in 27% of patients.

Once adequate circulation is confirmed by the Allen test, prep and drape the forearm. Inject local anesthetic, and use a micropuncture set to place a 4F or 5F sheath in the radial artery. If the radial artery is difficult to locate, map the vessel out with a Doppler probe. Also, a nitrate patch applied to the wrist will produce a 10% increase in the diameter of the radial artery. Once the sheath is inserted, open the stopcock on the sheath briefly and pulsatile arterial backflow will confirm adequate positioning of the sheath within the artery. Infuse 10 mL “radial artery cocktail” into the sheath as a measure to minimize the risk of vasospasm and thrombosis of the radial artery. Unlike sheaths in the femoral artery, a continuous heparinized saline pressure bag is not used with a radial sheath, due to the pressure and pain it can produce. An alternative to using a sheath is to use a 3F Angioptic™ catheter (AngioDynamics, Queensbury, NY) directly in the radial artery. After completion of the angiogram, remove the sheath and/or catheter and apply a pressure dressing to the wrist. The patient can sit up immediately.

**Radial Artery Cocktail**

Ten mL of saline containing heparin (5,000 IU), verapamil (2.5 mg), cardiac lidocaine (2%, 1.0 mL), and nitroglycerin (0.1 mg). (Enjoy responsibly.)
**Selected Patient-Specific Considerations**

1. **Patients receiving heparin**: The heparin infusion should be stopped 6 h prior to the angiogram.
   - (a) If the need is urgent, an angiogram can still be done in patients on heparin or who are coagulopathic with minimal risk. The initial puncture should be made with a micropuncture set to minimize potential bleeding.

2. **Patients receiving warfarin**: Hold Warfarin (and place the patient should be placed on a heparin infusion or low-molecular weight heparin if necessary) until the INR $\leq 1.4$.

3. **Patients receiving metformin**: See below.

4. **Thrombocytopenia**: Minimum platelet count for angiography is 75,000/µL.

5. **Diabetic patients**:
   - (a) Patients taking insulin: Reduce the insulin dose to half of the usual dose on the morning of the procedure, when the patient is NPO. Do the procedure as early in the day as possible, and the patient's usual diet and insulin should then be resumed.
   - (b) Patients taking metformin-containing oral anti-hyperglycemic medications: See below.
   - (c) Protamine should not be used to reverse heparin if the patient has received neutral protamine Hagedorn (NPH) insulin.

6. **Pregnant patients**: Every effort should be made to study pregnant patients noninvasively. Occasionally, a catheter angiogram is necessary (e.g., head and neck trauma with possible vascular injury, spontaneous epistaxis, intracranial AVM). Cerebral angiography can be performed safely during pregnancy.
   - (a) Informed consent of the patient or guardian should include a theoretical risk of injury to the fetus.
   - (b) Current recommendations for radiation exposure of the fetus include a maximum dose of 0.5 rem (roentgen-equivalent-man).
   - By shielding the uterus with a lead apron, the maximum dose to the fetus is less than 0.1 rem during cerebral angiography.
   - In general, fetal malformations only occur above a threshold dose of 100–200 mGy (~10–20 rem).
   - (c) Iodinated contrast agents are physiologically inert and pose little risk to the fetus.
   - (d) Provide adequate hydration to avoid fetal dehydration.
   - (e) Fluoroscopy: Minimize time and pulse/s during the procedure.
   - (f) Decrease fps during diagnostic runs to a minimum.

7. **Pediatric patients**: See below.

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**Contrast-Induced Nephropathy**

Iodinated contrast-induced nephropathy usually appears as an acute worsening in renal function within 3–4 days of the procedure. Contrast-induced nephropathy is usually defined as an increase in serum creatinine of 25–50% over baseline, or an absolute rise in serum creatinine of 0.5–1 mg/dL. Patients with renal insufficiency are up to ten times more likely to develop contrast-induced renal failure with administration of iodinated contrast than patients in the general population. Patients with renal insufficiency (creatinine $\geq 1.5$ mg/dL) require measures to minimize the risk of contrast-induced injury nephropathy during angiography. Nonionic, low-osmolality contrast agents, such as ioxaglate (Visipaque™, GE Healthcare, Princeton, NJ) and iopromide (Ultravist®, Schering, Berlin) have been shown to be less renal-toxic when compared to iohexol (Omnipaque®). The smallest possible amount of contrast should be used during the procedure. One of the authors was able to do a carotid angioplasty and stent procedure using a total of 27 mL of Visipaque™ by diluting the contrast with saline and using it sparingly. Forty-eight hours should be allowed to elapse between procedures utilizing iodinated contrast when possible. The antioxidant, N-acetylcysteine (Mucomyst®, Bristol-Myers Squibb, New York) is thought to function as a free-radical scavenger and to stimulate intrarenal vasodilation. Acetylcysteine was shown in a randomized trial to reduce serum creatinine elevation in patients undergoing radiological procedures using non-ionic, low osmolality contrast material. Prophylactic administration of acetylcysteine (600 mg PO BID) and 0.45% saline IV, before and after administration of the contrast agent, leads to a significant decrease in serum creatinine compared to patients.
receiving saline only. Subsequently, isotonic IV fluid was found to be superior to half-
isotonic IV fluid in reducing the incidence of contrast-induced nephropathy in patients
undergoing coronary angioplasty.79 Gadolinium contrast has also been used as a non-
iodinated contrast agent in cerebral angiography,80,81 but extensive testing has not been
done to ensure the safety of gadolinium compounds in the cerebral arteries. Hemo
filtration has been shown to reduce creatinine elevations after angiography.82 For patients with
dialysis-dependent renal failure, arrangements should be made with the patient’s neph-
rologist to schedule dialysis after the angiogram.

### Risk Factors for Contrast-Induced Nephropathy

- Serum creatinine level ≥1.5 mg/dL
- Diabetes mellitus
- Dehydration
- Cardiovascular disease and the use of diuretics
- Age ≥60 years
- Paraproteinemia (e.g., multiple myeloma)
- Hypertension
- Hyperuricemia

The patients at greatest risk for contrast nephrotoxicity are those with both diabetes
and renal insufficiency.83,84

### Methods to Reduce Risk of Contrast-Induced Nephropathy

- Minimize the use of contrast
- Use Visipaque76 (270 mL I/mL) instead of Omnipaque™76
- PO hydration (water, 500 mL prior to the procedure and 2,000 mL after the procedure)
- IV hydration with 0.9% sodium chloride79
- Acetylcisteine 600 mg (3 mL) PO BID on the day before and the day of the
  procedure78

### Metformin

Metformin is an oral anti-hyperglycemic and is used in several preparations (listed
below). Metformin-associated lactic acidosis is rare but has been reported to have a mor-
tality rate as high as 50%.85 Metformin use should be held for 48 h after the procedure,
and restarted only after serum creatinine has been checked and found to be unchanged.
The procedure may be done even if the patient has taken metformin earlier on the same
day of the procedure.86 Although metformin use seems to be associated with lactic acido-
sis, a systematic review article has questioned whether there is a causal relationship.87

### Metformin-Containing Medications

- Metformin (generic)
- Glucophage®
- Avandamet®
- Glucovance®
- Metaglip®

### Anaphylactic Contrast Reactions: Prevention and Management

Although the overall rate of anaphylactic iodinated contrast reactions with IV
administration is 0.7–2%,88,89 the rate of anaphylactic reactions with cerebral angiography
is much lower. This is thought to be because a passage of a bolus of contrast through the
pulmonary vasculature, which occurs with IV administration, is more likely to incite an anaphylactic reaction than the relatively diluted dose given during an arteriogram. Large series of cerebral angiograms have reported the following incidences of allergic reactions:

0 out of 1,358 cases (0/1,358), \(^90\) 0/2,154, \(^90\) 1/2,924, \(^92\) and 0/3,636. \(^94\)

### Risk Factors for Contrast Reactions

- History of a reaction to iodinated contrast agents (except flushing, a sensation of heat, or a single episode of nausea)
- History of serious allergic reactions to other materials
- Asthma
- Renal insufficiency
- Significant cardiac disease (e.g., patients with angina, congestive heart failure, severe aortic stenosis, primary pulmonary hypertension, severe cardiomyopathy)
- Anxiety

Previous reaction to contrast medium is the most important risk factor in the prediction of an adverse event. \(^94\) Patients who have had a previous reaction to ionic contrast may not have a reaction to nonionic agents. \(^95\) A history of seafood allergies, without a specific history of an iodine reaction, usually indicates a hypersensitivity to allergens in seafood, and does not indicate that the patient is unable to tolerate contrast media. \(^96\)

Premedication with steroids can reduce the risk of a serious contrast reaction. \(^97\) Repeat contrast reactions in patients with a history of previous reactions to iodinated contrast occur in 10–18% of cases despite premedication. \(^89,98\)

Gadolinium has been used for cerebral angiography in patients with a sensitivity to iodinated contrast material. \(^81,99\) However, IA gadolinium produces images that are reduced in quality compared to iodinated contrast, and patients undergoing coronary angiography with gadolinium have relatively high rate (21%) of complications, such as cardiac arrhythmias and hemodynamic instability. \(^100\)

### Premedication Regimen

1. Prednisone 50 mg PO (or hydrocortisone 200 mg IV) 13, 7, and 1 h prior to contrast injection
2. Diphenhydramine (Benadryl®) 50 mg IV, IM or PO 1 h prior to contrast injection

Steroids should be given at least 6 h prior to the procedure; administration less than 3 h prior to the procedure does not reduce the risk of an adverse reaction. \(^86\)

### Acute Contrast Reactions: Signs and Symptoms

- Cutaneous signs (flushing, urticaria, pruritis)
- Mucosal oedema
- Generalized oedema
- Sudden loss of consciousness
- Hypotension + tachycardia (anaphylactic reaction)
- Hypotension + bradycardia (vasovagal reaction)
- Respiratory distress

### Acute Contrast Reactions: Treatment

Effective treatment depends on prompt recognition of the problem and rapid management (Table 2.4). \(^101\)

### Intraoperative Angiography

Intraoperative angiography is employed by some neurosurgeons during surgery for intracranial aneurysms and arteriovenous malformations. In aneurysm surgery, intraoperative angiography findings, such as residual aneurysm or parent vessel compromise, have led to reexploration and clip adjustment in up to 12.4% of cases. \(^102,103\) Factors associated with a need for revision include large aneurysm size, \(^102\) the superior hypophyseal artery and clinoidal segment locations, \(^102\) and the occurrence of an intraoperative
Table 2.4 Management of acute contrast reactions in adults

<table>
<thead>
<tr>
<th>Condition</th>
<th>Management</th>
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<tr>
<td><strong>Urticaria</strong></td>
<td>1. Discontinue procedure if not completed</td>
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<td>2. No treatment needed in most cases</td>
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<td>3. Give H₁-receptor blocker: Diphenhydramine (Benadryl®) PO/IM/IV 25–50 mg. If severe or widely disseminated: alpha agonist (arteriolar and venous constriction) Epinephrine SC (1:1,000) 0.1–0.3 mL (=0.1–0.3 mg) (if no cardiac contraindications)</td>
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<td><strong>Facial or laryngeal edema</strong></td>
<td>1. Give alpha agonist (arteriolar and venous constriction): Epinephrine sc or IM (1:1,000) 0.1–0.3 mL (=0.1–0.3 mg) or, if hypotension evident, Epinephrine (1:10,000) slowly IV 1 mL (=0.1 mg). Repeat as needed up to a maximum of 1 mg</td>
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<td>2. Give O₂ 6–10 L/min (via mask)</td>
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<td>3. If not responsive to therapy or if there is obvious acute laryngeal edema, seek appropriate assistance (e.g., cardiopulmonary arrest response team)</td>
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<td><strong>Bronchospasm</strong></td>
<td>1. Give O₂ 6–10 L/min (via mask)</td>
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<td>2. Monitor: electrocardiogram, O₂ saturation (pulse oximeter), and blood pressure</td>
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<td>3. Give inhaled beta-agonist [bronchiolar dilator, such as albuterol (Proventil® or Ventolin®)], 2 to 3 puffs from metered dose inhaler. Repeat PRN. If unresponsive to inhalers, use SC, IM, or IV epinephrine</td>
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<td>4. Give epinephrine SC or IM (1:1,000) 0.1–0.3 mL (=0.1–0.3 mg) or, if hypotension evident, Epinephrine (1:10,000) slowly IV 1 mL (=0.1 mg)</td>
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<td>5. Repeat as needed up to a maximum of 1 mg</td>
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<td><strong>Hypotension with tachycardia</strong></td>
<td>1. Legs elevated 60° or more (preferred) or Trendelenburg position</td>
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<td>2. Monitor: electrocardiogram, pulse oximeter, blood pressure</td>
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<td></td>
<td>3. Give O₂ 6–10 L/min (via mask)</td>
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<td>4. Rapid intravenous administration of large volumes of isotonic Ringer’s lactate or normal saline</td>
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<td><strong>Hypotension with bradycardia</strong></td>
<td>1. Monitor vital signs</td>
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<td></td>
<td>2. Legs elevated 60° or more (preferred) or Trendelenburg position</td>
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<td></td>
<td>3. Secure airway: give O₂ 6–10 L/min (via mask)</td>
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<tr>
<td></td>
<td>4. Secure IV access: rapid fluid replacement with Ringer’s lactate or normal saline</td>
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<td></td>
<td>5. Give atropine 0.6–1 mg IV slowly if patient does not respond quickly to steps 2–4</td>
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<td></td>
<td>6. Repeat atropine up to a total dose of 0.04 mg/kg (2–3 mg) in adult</td>
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<td></td>
<td>7. Ensure complete resolution of hypotension and bradycardia prior to discharge</td>
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<tr>
<td><strong>Hypertension, severe</strong></td>
<td>1. Give O₂ 6–10 L/min (via mask)</td>
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<tr>
<td></td>
<td>2. Monitor electrocardiogram, pulse oximeter, blood pressure</td>
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<tr>
<td></td>
<td>3. Give nitroglycerine 0.4 mg tablet, sublingual (may repeat ×3); or, topical 2% ointment, apply 1 in. strip</td>
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<td></td>
<td>4. Transfer to intensive care unit or emergency department</td>
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<td>5. For pheochromocytoma – phentolamine 5 mg IV</td>
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(continued)
rupture. A portable C-arm digital subtraction angiography unit is necessary for intraoperative angiography, and a radiolucent head holder (Ohio Medical Instruments, Cincinnati, OH) and radiolucent operating table (Skytron, Grand Rapids, MI) are helpful, although adequate intraoperative imaging can be done even without radiolucent hardware. A femoral artery sheath should be placed prior to the operation. Use of a braided sheath will prevent kinking if the patient is moved after sheath placement. Continuous infusion of heparinized saline (5,000 U in 500 mL saline on a pressure bag at 3 mL/h) will maintain the patency of the sheath without a perceptible effect on systemic coagulation. A technique for intraoperative angiography for anterior circulation aneurysms by injection of contrast into the superficial temporal artery has also been described.

Paediatric Cerebral Angiography

Use noninvasive imaging modalities whenever possible. Although neurological complications are rare, children have higher rates of femoral artery access complications than adults do. In a series of 176 paediatric cerebral angiograms, no neurological complications occurred but puncture site complications (groin hematoma, bleeding, or reduced pedal pulse) occurred in 4.5%.

Access

1. Draping: use small aperture drape for the groin, and a regular femoral angiography drape for the rest of the angio table.
2. Newborns: the umbilical artery and vein can be used to access both arterial and venous circulations which allow for fairly easy catheterization.
3. The femoral artery is surprisingly superficial.
4. The femoral artery in children is prone to catheter-induced vasospasm, so minimize the amount of manipulation and the size of devices (e.g., use a micropuncture kit and small catheters).
5. Work without a sheath if possible.
6. Caveat: Initial catheterization of the femoral artery is sometimes surprisingly difficult because of the integrity of the connective tissue around the femoral artery; be sure that the wire that is used to introduce the diagnostic catheter is size-matched to the catheter to facilitate entry.
7. A twisting action can be helpful as the catheter is passed into the femoral artery.
8. A 20 or 22 gauge butterfly needle is useful for the initial femoral artery puncture (hint: cut clear the plastic tubing off the butterfly needle hub).
9. Sometimes an ultrasound-guided needle (e.g., Smart-needle®, Vascular Solutions, Minneapolis, MN) (20 gauge or smaller) is helpful.
10. Femoral artery puncture site management:
   (a) When compressing the artery after removal of the catheter, pay close attention to the distal lower extremity to ensure adequate perfusion. Overly aggressive manual compression or trauma to the femoral artery can result in long-standing femoral artery stenosis or occlusion, leading to limb atrophy.
   (b) After compression, the hip and lower extremity can be immobilized by taping or strapping it to an IV board.

Catheters

1. Catheters should be small in calibre and short in length (to minimize dead space in the catheter) (≤60 cm).
2. Newborns and young infants:
   (a) 3F Harwood-Nash.
      - Very peculiar curve makes it easy to access the left subclavian artery but difficult to navigate into the aortic arch
      - Requires a small guidewire (e.g., 0.018–0.025 in. steerable hydrophilic wire)
3. Older infants and young children:
   (a) 4F Pediatric Berenstein
   (b) 4F Harwood-Nash
4. All paediatric patients:
   (a) 3F Angioptic™ (AngioDynamics, Queensbury, NY).
      - Comes in steam-shapeable straight or curved configurations
      - Use a 21 gauge needle and a small guidewire (e.g., 0.018–0.021 in. steerable hydrophilic wire)

Saline, Contrast Dose, and Volume Considerations

1. Use less heparin in the flush: Saline with 1 units of heparin per mL
2. Double flushing with heparinized saline: Be careful to aspirate the minimum amount of blood to minimize blood loss and heparin dose
3. Use small syringes (3 mL or 5 mL) to limit the amount of volume
4. Limit contrast to 4 mL of Omnipaque® 300 per kg body weight
5. Limiting volume is particularly critical in children with Vein of Galen malformations, as these patients often have some degree of high-output congestive heart failure

Imaging Parameters and Radiation Exposure

1. Image intensifier:
   (a) Use a small field of view.
   (b) Remove the filter if possible.
   (c) Lower the X-ray dose as much as possible.
2. Limit fluoroscopy time.
3. Lower the pulse rate during fluoroscopy (e.g., 3–6 fps).
4. Maximize collimation to minimize scatter.
5. Use “low-dose fluoro option” if available as a part of the imaging equipment.
6. Place a lead shield under the gonads if possible.


Atherosclerotic Carotid and Vertebrobasilar Disease

- Aortic arch angiogram: identifies aortic atheromas and common carotid artery lesions, and helps planning for potential carotid angioplasty and stenting procedures.
To image the carotid bifurcation, on the PA and lateral views, place the angle of the mandible in the center of the image.

Oblique views are sometimes necessary to obtain the optimal view of an atherosclerotic plaque.

When high grade stenosis prevents passage of enough contrast to image the internal carotid artery (ICA), the degree of stenosis can be estimated using the diameter of the contralateral ICA.

The vertebral artery origin is best seen with an AP Townes view, because the vertebral artery arises from the posterior wall of the subclavian artery (see Fig. 1.37).

The intracranial vertebral arteries and basilar artery are best seen with an AP Waters view, because the basilar artery travels parallel to the clivus, which is tilted anteriorly in the sagittal plane.

### Intracranial Aneurysms

- A complete four-vessel angiogram should be done in the setting of subarachnoid haemorrhage, as two or more aneurysms will be found in 15–20% of patients.
- Selective catheterization of the ICA will prevent branches of the ECA from obscuring the intracranial images.
- External carotid angiography may be needed in aneurysm cases if an extracranial to intracranial arterial bypass is anticipated for surgical treatment, in order to visualize possible donor vessels.
- If a study is done in the setting of subarachnoid haemorrhage, and no aneurysm is found on internal carotid arteriography, external carotid angiography may be useful to rule out an arteriovenous fistula (see below).
- Aneurysm dome, neck, parent vessel, and adjacent vessels should be discerned.
- 3-D angiography is very helpful in determining configuration of the aneurysm neck.

### Cerebral Arteriovenous Malformations

- All feeding arteries and draining veins should be identified; this usually requires a complete bilateral internal carotid, external carotid, and vertebral angiogram.
- High-speed runs (>5 fps) can help clarify anatomy of AVMs, as they are typically high-flow lesions. High-speed runs may also permit more precise measurements of arteriovenous transit times.
- Intranidal aneurysms can be identified and distinguished from enlarged veins by their location on the arterial side of the nidus. In contrast, nidal “pseudoaneurysms” have been described in the arterial or venous side of the nidus; they can be recognized when they appear as a new finding on subsequent angiography.
- Small, obscure AVMs may sometimes be made to be more apparent on angiography by having the patient deliberately hyperventilate for several minutes. Normal vessels will constrict and AVM vessels will be unchanged (Cure, 2007, personal communication).

### Cerebral Proliferative Angiopathy

(see Chap. 14)

- A complete 6-vessel angiogram should be done (bilateral internal and external carotid and vertebral arteries), to identify meningeal feeders, which are frequently present.
- Feeding vessels (such as the ICAs and M1 segments) should be imaged well to look for the presence of arterial stenosis.
Dural Arteriovenous Fistulas

- All feeding vessels should be identified; selective catheterization of branches of the external carotid artery is usually necessary.
- After each injection, the angiogram should be allowed to continue until the draining vein (or venous sinus) is imaged.
- On internal carotid and vertebral injections, the venous drainage pathways of the normal brain must be determined to see how it relates to the drainage pathways of the fistula.

Direct (High-Flow) Carotid-Cavernous Fistulas

- High-speed runs (>5 fps) are usually helpful.
- Huber maneuver: Injection of contrast into the ipsilateral vertebral artery with manual compression of the carotid artery; reflux of contrast into the carotid artery can demonstrate the defect in the cavernous carotid artery.\(^\text{113}\)
- Slow injection into the internal carotid artery with compression of the carotid artery below the catheter tip in the neck can also demonstrate the defect in the vessel.\(^\text{114}\)
- Special attention should be given to venous drainage and determining whether there is a retrograde cortical venous flow.

Aortic Arch

- Angiography of the aortic arch is best done with a power injector and a pigtail catheter positioned in the ascending aorta. The optimal projection is left anterior oblique, 30°, with the patient’s head rotated to the left to face the image intensifier. Power injector settings are 20 mL/s; total of 25 mL.
- For these high-volume injections care should be taken that the injection pressure does not exceed the nominal rating for the catheter and any stopcock.

Assessment of the Circle of Willis

- Patency and calibre of the posterior communicating artery can be assessed with the Huber (or Allcock) manoeuvre: Injection of contrast into the ipsilateral vertebral artery with manual compression of the carotid artery; reflux of contrast into the carotid artery can demonstrate posterior communicating artery.
- The anterior communicating artery can be demonstrated by “cross compression” of the carotid artery. Manual compression of the contralateral common carotid artery while wearing a lead glove during injection of contrast into the ipsilateral internal carotid artery will help visualize the anterior communicating artery.

Carotid Siphon and MCA Candelabra

- The “Haughton view” can be used to open up the carotid siphon (useful for imaging the origins of the P-comm and anterior choroidal arteries) and to unfurl the branches of the MCA within the Sylvian fissure. This view is also helpful for imaging ICA and MCA aneurysms. The lateral arc is positioned as if the patient’s head is tilted away from the side of the injection and away from the X-ray tube (see Fig. 2.5).
References


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