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## MRI and MRA in spontaneous intracranial arterial dissection

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A 19-year-old man, previously asymptomatic, presented with acute onset headache followed by right hemiplegia and global aphasia. A diffusion weighted MRI showed acute infarct of the left middle cerebral artery (MCA) territory [Figure 1A]. Three-dimensional Multiple Overlapping Thin Slab Acquisition (MOTSA) MR Angiography [Figure 1B] and source images showed dissection of M1 segment of the left MCA.<sup>[1]</sup> The dissection was predicted on conventional imaging as a double lumen was visible on T2 weighted and proton density cross-sectional images of the M1 segment [Figure 1C]. Digital subtraction angiography (DSA) showed only occluded left Middle Cerebral Artery (MCA) with irregular dilatation of left supraclinoid portion of Internal Carotid Artery (ICA) [Figure 1D].

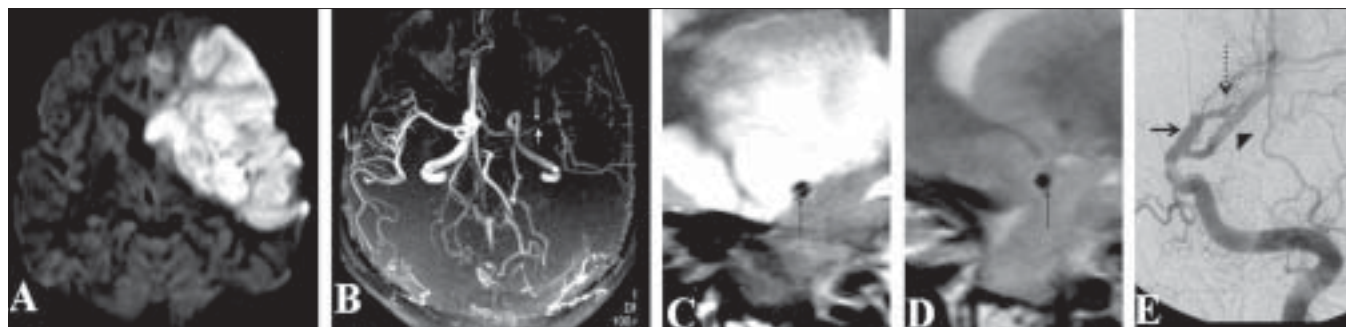
Arterial dissection is being increasingly recognized as a cause of stroke in the young. However, its occurrence

in the absence of systemic diseases or antecedent trauma is extremely uncommon in the intracranial circulation.<sup>[2]</sup> Appropriate proton density image may occasionally be the only sequence demonstrating the changes on conventional imaging and should be carefully looked for. Invasive procedures like DSA may not be of added use and should be judiciously used.

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**Figure 1:** (A) Diffusion weighted sequence shows the typical restricted diffusion in acute left MCA infarct. (B) MIP of TOF MR angiography shows the thin channel of left MCA, with reduced number of cortical branches. (C) Left parasagittal T2 weighted image shows the flap with double lumen appearance of left M1 in cross-section (arrow). (D) The unaffected right M1 for comparison. (E) Left carotid angiography in oblique view shows the dilated segment of supraclinoid ICA (arrow) ending in occluded left MCA (dotted arrow). Note the prominent posterior cerebral artery origin from ICA (arrow head)