

symptoms including confusion, amnesia, seizures, cerebral ischaemic vasculopathy, and coma.

When air embolism is suspected, the patient should be placed in the Trendelenburg position or left lateral decubitus position to favour the return of air to the central venous circulation. Administration of 100% oxygen in a hyperbaric chamber is recommended to treat hypoxia and hypoxaemia and to remove air bubbles from the brain, using a diffusion gradient favouring air exit.^{12,13}

Air embolism should be suspected in patients with CVC who present unexplained neurological symptoms after manipulation or insertion of the catheter; early diagnosis and treatment are essential to prevent irreversible sequelae.

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Incidence of Guillain-Barré syndrome during the Zika virus outbreak[☆]

Incidencia del síndrome de Guillain-Barré durante el brote de virus del Zika

Dear Editor:

It was with great interest that we read the article "Incidence of Guillain-Barré syndrome at a secondary cen-



tre during the 2016 Zika outbreak."¹ The authors point out that "cases of Guillain-Barré syndrome increased during the Zika outbreak, with an increase in incidence and number of cases per month," but are unable to establish a direct causal relationship between the 2 conditions. This is a relevant finding. We would like to contribute some ideas and experiences on this subject by comparing the situation in tropical South America, described by del Carpio et al., to that of tropical Southeast Asia, where an outbreak of Zika virus infection was also reported. In this region, the incidence of Guillain-Barré syndrome did not increase during the outbreak.² In fact, Zika virus infection has a broad clinical spectrum³; in tropical Asia, the infection is either asymptomatic or manifests with mild symptoms, with no associated complications.⁴

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Carotid pseudo-occlusion: a concept to consider in acute stroke[☆]



Pseudooclusión carotídea: un concepto a tener en cuenta en el ictus agudo

Dear Editor:

Pseudo-occlusion (PO) of the cervical internal carotid artery (ICA) is defined as a flow artefact on CT angiography or digital subtraction angiography (DSA) images that mimics a complete occlusion of the extracranial carotid artery, when this arterial segment is in fact patent, with occlusion of the intracranial segment.¹ This finding may influence the management of patients attended in the emergency department due to acute stroke, leading to misdiagnosis of tandem occlusion of the extracranial–intracranial ICA or arterial dissection and resulting in endovascular treatment being delayed or even ruled out.

We present the case of a patient with acute ischaemic stroke due to a thrombus in the left intracranial ICA that created an image of carotid PO at the cervical level. A brief literature review is provided.

Our patient was a 55-year-old woman, with a history of smoking, arterial hypertension, dyslipidaemia, and paroxysmal atrial fibrillation, for which she was not receiving anticoagulant treatment. She awoke with speech difficulties and weakness in the right limbs and was taken to the emergency department. The neurological examination

revealed predominantly motor mixed aphasia, right homonymous hemianopsia with conjugate eye deviation to the left, right faciobrachiorucral hemiparesis, and right hemihypaesthesia. She presented an NIHSS score of 22 points. An emergency brain CT scan showed loss of cortico-subcortical differentiation of the left insula and hypodensities in the left caudate and lenticular nuclei, scoring 7 on the ASPECTS scale. A CT perfusion scan showed an extensive penumbra and the results of a CT angiography study suggested occlusion of the left ICA from its origin, displaying the carotid slim sign (Fig. 1); these findings were considered to suggest carotid artery dissection. The patient was transferred to the interventional neurology department; DSA study showed contrast progressively flowing up through the left ICA to the intracranial portion (Fig. 2). After confirming the presence of arterial occlusion in the terminal portion of the left ICA only, we performed thrombus extraction by mechanical thrombectomy with a stent retriever, achieving complete recanalisation (TICI grade 3) with a single pass.

The following day the patient had improved, scoring 6 on the NIHSS scale. At a 3-month follow-up examination she presented minimal neurological impairment, scoring 1 on the modified Rankin Scale.

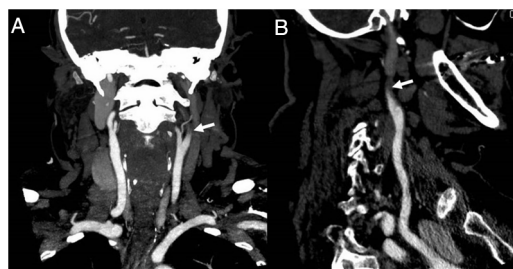


Fig. 1 Coronal (A) and sagittal (B) CT angiography images suggestive of occlusion of the left internal carotid artery from its origin, showing the slim sign.

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