



Get Clarity On Generics

Cost-Effective CT & MRI Contrast Agents



FRESENIUS
KABI

WATCH VIDEO

AJNR

Reply:

S. Bracco and E. Bertelli

AJNR Am J Neuroradiol 2016, 37 (11) E73

doi: <https://doi.org/10.3174/ajnr.A4910>

<http://www.ajnr.org/content/37/11/E73>

This information is current as
of August 21, 2025.

REPLY:

We thank Drs Paruthi, Gupta, and Khandelwal for drawing our attention to the issue of the rare embryologic variations one can encounter performing intra-arterial chemotherapy. Indeed, they can represent challenging scenarios for the neurovascular interventionalist. In our series of eyes treated for intraocular retinoblastoma, we did not face rare variants such as those encountered by Paruthi et al and, therefore, did not discuss the subject. Nevertheless, we believe that the case reported by Paruthi et al illustrating a combination of very unfortunate events (a too-angulated ophthalmic artery stemming and a type 1 persistent trigeminal artery) strengthens the concept that the neurovascular interventionalist must be prepared to adapt the technical approach on the basis of the circumstances.¹

Anatomic and hemodynamic variations may require the exploration of several possible alternative pathways of intra-arterial drug delivery from the external carotid artery (ECA)² or the use of the balloon technique occluding the ICA or the ECA.^{3,4} In the specific case addressed by Paruthi et al, we agree that the disappearance of the ophthalmic artery (OA) after ICA occlusion was due to hemodynamic alterations of the blood flow, but we suggest a different interpretation of such changes. In our opinion, the missing OA opacification could likely be the result of a reversal of flow in the OA related to the occlusion of the ICA rather than to the preferential retrograde flow to the posterior circulation through the primitive trigeminal artery. Thus, we believe that the

authors would have to verify with the microcatheter the possible reformation of the OA by branches of the ECA during occlusion of the ICA before giving up on the procedure. On the other hand, we agree with Paruthi et al that the use of 2 balloons in a single artery of an infant would have been an unsafe procedure.

REFERENCES

1. Bertelli E, Leonini S, Galimberti D, et al. **Hemodynamic and anatomic variations require an adaptable approach during intra-arterial chemotherapy for intraocular retinoblastoma: alternative routes, strategies and follow-up.** *AJNR Am J Neuroradiol* 2016;37:1289–95 [CrossRef Medline](#)
2. Bracco S, Venturi C, Leonini S, et al. **Transorbital anastomotic pathways between the external and internal carotid systems in children affected by intraocular retinoblastoma.** *Surg Radiol Anat* 2016;38:79–87 [CrossRef Medline](#)
3. Suzuki S, Yamane T, Mohri M, et al. **Selective ophthalmic arterial injection therapy for intraocular retinoblastoma: the long-term prognosis.** *Ophthalmology* 2011;118:2081–87 [CrossRef Medline](#)
4. Abruzzo TA, Geller JI, Kimbrough DA, et al. **Adjunctive techniques for optimization of ocular hemodynamics in children undergoing ophthalmic artery infusion chemotherapy.** *J Neurointerv Surg* 2015;7:770–76 [CrossRef Medline](#)

 **S. Bracco**

Unit of Neuroimaging and Neurointervention
Azienda Ospedaliera Universitaria Senese
University of Siena, Policlinico “Santa Maria alle Scotte”
Siena, Italy

 **E. Bertelli**

Department of Molecular and Developmental Medicine
University of Siena
Siena, Italy

<http://dx.doi.org/10.3174/ajnr.A4910>