A 66-year-old woman presented with intermittent paraparesis and generalized tonic-clonic seizure. Cerebral angiography demonstrated dural arteriovenous fistula (AVF) involving superior sagittal sinus (SSS), which was associated with SSS occlusion on the posterior one third. The dural AVF was fed by bilateral middle meningeal arteries (MMAs), superficial temporal arteries (STAs) and occipital arteries with marked retrograde cortical venous reflux. Transcranial arterial Onyx embolization was performed through right MMA and STA, but it was not successful, which resulted in partial obliteration of dural AVF because of tortuous MMA preventing the microcatheter from reaching the fistula closely enough. Second procedure was performed through left MMA accessed by direct MMA puncture following small decortications of cranium overlying the MMA using diamond drill one week later. Microcatheter could be located far distally to the fistula through 5 F sheath placed into the MMA and complete obliteration of dural AVF was achieved using 3.9 cc of Onyx.

Key Words : Dural arteriovenous fistula · Superior sagittal sinus · Transcranial · Middle meningeal artery · Onyx embolization.
Angiography depicted a dAVFs on the SSS fed by both MMAs, superficial temporal arteries (STAs) and occipital arteries (OAs) and drained into the occluded SSS retrograde fashion, then marked reflux to bilateral superficial cortical veins. There was no feeder from both internal carotid arteries. Because the SSS was occluded at the posterior one third, most cerebral venous outflow was drained into deep venous system through internal cerebral vein and straight sinus to transverse sigmoid sinus (Fig. 2). These dAVFs were classified as type IIa+IIb according to Cognard et al.1

**Endovascular embolization**

**1st embolization**

Under the general anesthesia, bilateral femoral arterial punctures were done. Through right femoral artery, a 6 F Envoy (Cordis, Miami, FL, USA) guiding catheter was advanced to the right external carotid artery (ECA). And a 5 F diagnostic catheter was placed to the left common carotid artery to evaluate the degree of dAVFs obliteration during the procedures. Initially, Echelon-10 (ev3 Neurovascular, Irvine, CA, USA) microcatheter was navigated through the 6 F guiding catheter, but it was very difficult to navigate the tortuous turning point beyond the foramen spinosum level (Fig. 3A). Thus, the microcatheter was changed to Marathon (ev3 Neurovascular, Irvine, CA, USA) catheter, however, it was impossible to get access the fistula portion. Thus Onyx in-
jection was done from the proximal frontal branch of MMA, but resulted in the incomplete obliteration.

So, we performed Onyx embolization from the petrosal branch of MMA and the parietal branch of STA. Total of 4 cc Onyx was injected during the first session through right ECA branches. However, the infiltration of Onyx into the fistula was not successful from these vessels (Fig. 3B, C).

2nd embolization

Even though her paraparesis was improved a lot after the first incomplete embolization of dural AVF, 2nd procedure was inevitable to prevent fatal hemorrhage, or seizure.

2nd embolization was composed of direct MMA puncture through the small decortication on the left frontal bone overlying the MMA beyond the turning point. After one week, left transcranial arterial embolization was performed under the general anesthesia in the angiosuite. She was placed on supine position and the head was rotated 60 degree to the opposite side. A 5 F diagnostic catheter was placed to left ECA with continuous heparinized saline irrigation. Under the roadmap guidance, exact location of MMA to be punctured was marked with drill tip (Fig. 4A). After a small semilunar shaped scalp incision was made, decortication of temporal bone using diamond drill was performed on the distal part of turning point of MMA (Fig. 4B). A 10 mg of verapamil was infused through the catheter to dilate the MMA because it was not large enough to puncture successfully.

Direct puncture of MMA using 20 G angioneedle was done without difficulty. Hairwire was inserted into the MMA and 5 F micropuncture sheath was placed over the wire. This sheath was fixed with black silk tie to prevent accidental removal during the procedures (Fig. 5). Through the sheath Echelon-10 (ev3 Neurovascular, Irvine, CA, USA) microcatheter was introduced and advanced to the fistula portion near the SSS. Microangiogram demonstrated dAVF clearly. Onyx injection (total 3.9 cc) from this single artery resulted in complete obliteration of AVF without remnant (Fig. 6). And on post operative angiogram, AVG from both STAs and OAs was also completely obliteration.

Postoperatively, she recovered well and her paraparesis was improved to normal. Diffusion weighted image showed no abnormal high signal lesion on brain parenchyma. Computerized tomography (CT) scan showed Onyx cast within the fistula and arterialized cortical veins.

DISCUSSION

DAVFs involving the SSS are rare but have aggressive clinical
Symptom and intracranial hemorrhage due to the venous hypertension. The resultant encephalopathy can be clinically demonstrated on dementia, gait ataxia, seizure, myelopathy, cerebral edema, ischemia, subarachnoid hemorrhage, or any combination of these signs and symptoms. If the cortical venous reflux persists, annual risk of hemorrhage or non hemorrhagic neurological deficits is known to be 15% along with an annual mortality rate of 10.4%. Cognard et al. noted intracranial hemorrhage in 10% of patients with type II, 40% with type III and 65% with type IV dAVFs.

Recently, there are many multimodality treatment modalities including compression, transvenous, transarterial embolization, surgery, and radiosurgery. In addition, especially on dAVFs involving the SSS, a combination of surgical and endovascular techniques, including direct-puncture transvenous embolization during surgery or transvenous alone has been described. And, stent placement for occluded sinus is another treatment option for dAVFs involving the SSS.

In this case, we considered many endovascular treatment options including transvenous coil embolization, SSS stenting, and transarterial Onyx embolization. Of these, transvenous coil embolization required surgical exposure of SSS, which had an disadvantage of excessive bleeding. Although SSS stenting could convert aggressive type to benign type, it was considered difficult because the length of occlusion was long.

Therefore, we decide to try transarterial embolization with Onyx. Onyx has an advantage of nonadhesive nature and penetration capability over n-butyl-2-cyanoacrylate. There have been many successful reports on transarterial Onyx embolization of dAVFs.

We tried transarterial Onyx embolization using MMA, however, it was not successful because of proximal tortuosity of MMA. If we can get access to the fistula through MMA, there is a high likelihood of complete obliteration of dAVF with Onyx. To overcome the proximal tortuosity of MMA, we performed direct MMA puncture.

Transcranial combined approach using direct puncture technique is sometimes very useful when a traditional transfemoral transarterial approach was failed. Many neurosurgeons have successfully treated for dAVFs using transcranial approach for venous embolization. We treated this case using transcranial approach for arterial embolization. Koh et al. reported transcranial transarterial approach with craniectomy for occlusion of dAVFs combined with SSS. In our case we used diamond drill to decoricate the temporal bone to prevent accidental damage to MMA and prevent the vassospasm.

**CONCLUSION**

Transcranial combines approach using direct puncture tech-