Abstract
The absence of the internal carotid artery (ICA) is a rare congenital anomaly. Diagnosis of this entity is important because of its association with the cerebral aneurysm and also indicated during planned carotid or transsphenoidal surgery in thromboembolic disease and in the surveillance and detection of associated cerebral aneurysms. We report a case of congenital absence of unilateral ICA with associated cerebral aneurysm of the anterior cerebral artery.

Keywords: Cerebral aneurysm, congenital absence of the internal carotid artery, hypertrophied posterior communicating artery

Introduction
Agenesis, aplasia, and hypoplasia of the internal carotid artery (ICA) are rare congenital anomalies, occurring in <0.01% of the population.[1,2] The term absence indicates agenesis, aplasia, and hypoplasia of the ICA. In the setting of an absence of ICA, the most common type of collateral flow is through the circle of Willis. Other less common collaterals are collateral flow through persistent embryonic vessels or from transcranial collaterals originating from the external carotid artery (ECA) system. Slightly more than 100 cases of congenital absence of the ICA have been reported in the literature.[3]

Case Report
A 60-year-old male presented with a headache for few months. Carotid Doppler revealed high-grade atherosclerotic stenosis of the proximal right ICA with poststenotic parvus–tardus waveforms [Figure 1]. Left carotid vessel showed high-resistance waveform with the absence of normal ICA waveform which suggested agenesis of the left ICA [Figure 1].

The patient underwent computed tomography (CT) angiography imaging of the carotid vessels and circle of Willis, which showed absent ICA on the left side and collateral flow to the left hemisphere through the circle of Willis [Figures 2-5].

The absence of the left carotid canal was noted at bone window setting of CT, which confirmed the congenital nature of the nonvisualization of left ICA [Figure 3]. Maximum intensity projection reconstruction revealed that the left middle cerebral artery (MCA) was supplied by the basilar artery through a dilated left posterior communicating artery (PCOM) [Figures 4 and 5].

The patient subsequently underwent magnetic resonance (MR) imaging of the circle of Willis, which showed the absence of flow-related signal intensity within the left ICA [Figure 3]. Saccular aneurysmal dilatation of the anterior communicating artery (ACOM) was detected on CT angiography (CTA) and MR angiography [Figures 4 and 5]. A1 segment of the left anterior cerebral artery (ACA) and right PCOM were not seen opacified on CTA and showed the absence of flow-related signal intensity suggested aplasia [Figure 5]. The remaining portion of left ACA was supplied by ACOM aneurysm.

Discussion
Agenesis of the ICA is a rare congenital vascular anomaly having an incidence of 0.01%.[1,2] In 1787, Tode was first to report the case of ICA agenesis on postmortem examination, and a number of cases of ICA agenesis have been reported until now.[3] In 1954, Verbiest recognized
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Most patients of ICA agenesis are asymptomatic because the circle of Willis provides sufficient collateral blood supply to the affected side of brain parenchyma. Later, patients may present with subarachnoid hemorrhage from aneurysmal rupture or transient ischemic attack due to vascular insufficiency.

Collateral circulation accompanying ICA agenesis is classified into three forms: (1) through the circle of Willis, (2) persistent embryonic vessels, and (3) transcranial anastomosis from the ECA. Tsuruta and Myazaki proposed three types of collateral channels through the circle of Willis. In Type I, the ipsilateral ACA is supplied by the contralateral ICA, opposite to the ICA agenesis, through the anterior communicating artery (ACoA). The MCA is supplied by the basilar artery through the posterior communicating artery. In Type II, the ipsilateral ACA and MCA are supplied by the transcranial ICA, opposite to the ICA agenesis, through the anterior communicating artery (ACoA). The MCA is supplied by the basilar artery through the posterior communicating artery. In Type III, the ipsilateral ACA and MCA are supplied by the transcranial anastomoses that develop from ECA or contralateral ICA or primitive vessels. In our case, Type I anastomosis was determined by CT and angiographic examination. Differentiating a hypertrophied
PCOM from a persistent trigeminal artery are generally easily accomplished with either MR or CT angiography as the PCOM’s origin from the supraclinoid ICA can be distinguished from the persistent trigeminal artery’s origin from the cavernous ICA.

Nonvisualization of an ICA on angiography and absent bony carotid canal in the base of the skull on CT is the imaging findings that must be included in the diagnosis of congenital absence of an ICA. In the absence of any of these findings, it may be confused with acquired stenosis or occlusion of the ICA, respectively.

Intracranial vascular anomalies can be associated with ICA agenesis as seen in our case. A higher incidence of intracranial aneurysm (25%-43%) has been reported in association with ICA agenesis in comparison to the general population (2%-4%). An aneurysm may develop secondary to hemodynamic disturbances or may form during embryonic life as a result of the developmental anomaly. In a series of six patients, Lee et al. reported that aneurysms developed ipsilateral side to the absent ICA, supporting a congenital origin of an aneurysm as opposed to hemodynamic factors. The saccular ACOM artery aneurysms in our case may have arisen secondary to hemodynamic stress on the right ACA and ACOM by supplying the left ACA.

Our patient has no complaints at present and is being followed up with periodic physical and neurological examination.

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Conflicts of interest
There are no conflicts of interest.

References