Fenestration and Phlebectasia of the Internal Jugular Vein

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Abstract

Objectives: We report a case of fenestration and phlebectasia of the right jugular vein with the spinal nerve passing between the branches of the fenestration. Through this case we discussed the surgical implications and review the literature.

Case Report: From 2013 to 2017, we conducted 1720 cervicotomies. On 1720 cervicotomies we found one case of fenestration and phlebectasia of the internal jugular vein that makes a rate of 0.058%. Cervicotomy was conducted as part of the management of neurofibroma. The outcome was good.

Conclusion: The knowledge of the anatomical variations of the internal jugular vein is imperative for any ENT surgeon especially in a context of deficient plateau that does not allow the most often to make the preoperative diagnosis.

Keywords: Fenestration; Phlebectasia; Internal jugular vein; Spinal nerve

Introduction

The internal jugular vein is the main vein of drainage of blood flow to the head and neck [1,2]. It constitutes an important anatomical benchmark in oncological surgery in the context of ganglion dissection [1]. In intensive care during the placement of the central venous catheter and in interventional radiology [3]. It is the site of numerous anatomical variations, notably duplication and fenestration [1,2,4]. The etiology of this fenestration remains obscure. Several hypotheses have been described occurring in the genesis of fenestration: neuronal; vascular, bone and muscle [2,5]. The mode of preoperative discovery is the most common [2]. However, angiography, magnetic resonance imaging and Doppler ultrasound allow for preoperative diagnosis [2,5-7]. Venous dilatation, its relationship with the spinal nerve and omohyoid muscle is a risk of bleeding during central catheterization and cervical surgery [1,2,4,6,8,9].

We reported a case of fenestration and phlebectasia of the right internal jugular vein, in relation to the spinal nerve which crossed the fenestration. Through this case we discuss the clinical implications and review the literature.

Case Presentation

From 2013 to 2018, we conducted 1720 cervicotomies. On 1720 cervicotomies we found a case of fenestration and phlebectasia of the internal jugular vein that makes a rate of 0.058%. Our clinical case concerned a 15-years-old patient who had undergone a cervicotomy for right lateral cervical mass that had been evolving for six months. The cervico-thoracic computed tomography showed a heterogeneous mass sitting at the lateral cervical level, compressive without invading neighboring structures. An exploratory cervicotomy with excision of the mass was made. After locating homo-hyoid muscle and internal jugular vein. We performed a dissection from the bottom up. We found phlebectasia of the internal jugular vein measuring approximately 2 cm × 1 cm (Figure 1). The dissection conducted along the vein revealed a splitting in the form of a window (fenestration) through which the spinal nerve passed between the branches. No operative accident was noted. Histological examination of the operative specimen found a neurofibroma.

Discussion

The fenestration of the internal jugular vein is an entity. Kevin J et al. reported their incidence of 0.3% to 3.3% [2]. The frequency of 0.058% concerned all patients who had undergone...
The internal jugular vein is a major anatomical marker in cervical surgery and in venous catheterization [8]. The presence of anatomical variations on this vein exposes the surgeon to operational difficulties with the risk of hemorrhagic vascular lesion and nerve injury [8]. It is an essential radiological reference [14]. A diagnostic error can be misinterpreted as thrombosis or lymphadenopathy [14]. In our case, the dissection of the internal jugular vein was carried out from the bottom up, with corollary the discovery of the fenestration. The careful dissection of the fenestration made it possible to locate the spinal nerve which passed through this fenestration. Dissection of the spinal nerve was performed retrograde. The fortuitous discovery of the fenestration associated phlebectasia in our patient constituted our surgical difficulty in terms of dissection. The presence of the spinal nerve through the fenestration made him vulnerable. The knowledge of this anatomic variation made it possible to avoid the operative incident by conducting a careful dissection.

Table 1: Review on fenestration of the internal jugular vein.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Year of publication</th>
<th>Number of Cases</th>
<th>Circumstances of discovery</th>
<th>The spinal nerve passes through the fenestration</th>
<th>Association with Phlebectasia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park Ju Young [7]</td>
<td>2011</td>
<td>1 Case</td>
<td>CT scan</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Atalar MH [11]</td>
<td>2012</td>
<td>1 Case</td>
<td>CT scan</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Yuriko Hashimoto [4]</td>
<td>2012</td>
<td>4 Cases</td>
<td>CT Scan</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pegot A [14]</td>
<td>2014</td>
<td>1 Case</td>
<td>Intraoperative</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Moreno-Sanchez M [5]</td>
<td>2015</td>
<td>1 Case</td>
<td>CT scan</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Contrera KJ [2]</td>
<td>2016</td>
<td>3 Cases</td>
<td>Intraoperative</td>
<td>Yes</td>
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<tr>
<td>Cvetko E [3]</td>
<td>2017</td>
<td>1 Case</td>
<td>Intraoperative cadaver</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Our Case Report</td>
<td>2018</td>
<td>1 Case</td>
<td>Intraoperative</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Figure 1: Neck dissection. Fenestration and phlebectasia of the right internal jugular vein. The spinal nerve passes through the fenestration.
Conclusion

The preoperative discovery allows the surgeon as well as the radiologist to prevent vascular and nervous accidents related to surgical practice and central venous catheterization on the neck. Preoperative finding is a risk for the nerve and vein especially in cases of phlebectasia. The knowledge of the anatomical variations of the internal jugular vein is imperative for any ENT surgeon especially in a context of deficient plateau that does not allow the most often to make the preoperative diagnosis.

References