Histopathological analysis of in vivo specimens of recurrent aneurysms after coil embolization

Chao Wang,1 Mengxing Li,1 Huiyuan Chen,2 Xinjian Yang,1,3 Ying Zhang,1 Dong Zhang4

INTRODUCTION

Unruptured intracranial aneurysms (IA) are common cerebrovascular conditions. Aneurysm rupture results in subarachnoid hemorrhage (SAH), which is an important subtype of stroke with high mortality and morbidity rates.1 Therefore, appropriate intervention is necessary for IA.2 The initial intervention method was microsurgical aneurysm clipping. After the development of catheterization techniques with cerebral angiography, endovascular coiling has become another way of treating IAs. Moreover, endovascular therapy improves patient quality of life immediately after treatment and during follow-up, and has a lower mortality rate than surgical clipping.1 3

Although endovascular therapy has been verified as safe and effective, IA recurrence may occur even after complete coil embolization of the aneurysm.4 The recurrence rate is relatively high after coiling alone and after stent-assisted coil embolization.1 5 IAIs often recur early after endovascular treatment. Nearly 50% of IA recurrences occur within 6 months after coiling in humans.1 Nearly 50% of IA recurrences occur within 6 months after coiling in humans.1 6 The mechanism of IA recurrence is complex and the specific processes are still unclear. Many hypotheses have been proposed for IA recanalization, including: (1) growth of the aneurysm itself,5 9 (2) coil compaction,7 10 (3) degradation and recanalization of fresh and unstable thrombotic tissue, (4) continuous blood flow through the intraluminal coils and thrombosis complex,11 (5) lack of neointima formation across the neck of the aneurysm,12 (6) lack of smooth muscle in the IA wall, leading to organized thrombus reduction.13 14 To solve the problem of IA recurrence, this study investigated the pathology of specimens collected from patients who underwent clipping after unsuccessful coil embolization.

PATIENTS AND METHODS

Between June 2019 and January 2021, eight patients with nine recurrent sacular aneurysms underwent surgery in our hospital. All patients had received previous embolization treatment before undergoing surgical clipping. Four patients with five recurrent aneurysms experienced SAH after embolization. The other four recurrent aneurysms in four patients were detected on follow-up imaging. In our former study,15 recurrent aneurysms were classified into the following five types: I, pure recanalization inside the aneurysm sac; II, pure coil compaction without aneurysm growth; III, new aneurysm neck formed without coil compaction; IV, new aneurysm neck formed with coil compaction; and V, newly formed aneurysm neck and sac. Types I–II can be resolved with endovascular treatment, while types III–V require surgical clipping. This strategy results in a satisfactory cure rate and complications. In the present study, four recurrent IAs (two type III, one type IV, and one type V) and five ruptured IAs in eight patients were analyzed. Patient and aneurysm information is presented in Table 1.

A standard endovascular technique was used to access and pack the IAs with coils as tightly as possible. Preoperative dual antiplatelet therapy (100 mg aspirin and 75 mg clopidogrel) was used during follow-up, and has a lower mortality rate than surgical clipping.1 3

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The microsurgical clipping was done via the supraorbital approach and the pterional approach. In patients with an IA in the posterior communicating artery, anterior communicating artery, middle cerebral artery, and communication segment of the internal carotid artery, microsurgical clipping was performed through the ipsilateral pterional approach. However, for patients with a less-developed frontal sinus and anterior orientation communicating artery aneurysms, clipping was performed via the ipsilateral supraorbital approach. Successful exclusion of the aneurysm and preservation of the branches was verified using intraoperative indocyanine green video angiography. The detailed surgical procedures are shown in online supplemental figures. Aneurysm specimens were carefully collected during surgery.

Aneurysms were inspected thoroughly after removal. The specimens were fixed in buffered formaldehyde and embedded in resin (methyl methacrylate). Serial sections were made using a diamond wire saw and hand polishing. Specimens were prepared using the standard of creating sections perpendicular to the aneurysm neck. Nine sections were stained with hematoxylin-eosin (H&E) and Masson stains. One integral specimen with void spaces), inflammatory response (foreign body giant cells, leukocytes, macrophages invasion), and thrombus organization (fibrocellular reaction, collagen formation, neovascularization), as well as the immunohistochemical staining results. Two or three slides were made from each aneurysm. All slides were studied in a similar manner and the most representative slide was selected for analysis. Detailed histological findings are shown in online supplemental table 1, using the histopathology result score16 (online supplemental tables 2–6).

### RESULTS

#### Patient characteristics and imaging findings

Before the first coiling, six patients with six aneurysms had SAH due to aneurysm rupture, and the three IAs in the other two patients were detected on imaging. Four patients received the second endovascular treatment for aneurysm rupture or recurrence (two patients were treated with coiling alone, and two were treated with stent-assisted coiling). Eight patients finally underwent surgical clipping because of post-coiling aneurysm recurrence or SAH during follow-up. Four patients with five aneurysms had an aneurysmal SAH and four patients with four aneurysms showed aneurysm recurrence on imaging. Seven patients with seven aneurysms, who did not take the antplatelet drug, accepted clipping directly. Only one patient with two aneurysms still took aspirin because the stent was placed during last endovascular treatment (2 months ago), then accepted conservative treatment until aspirin withdrawal after 1 week, and finally received clipping.

The surgical series included five men and three women with a mean age of 56±10.3 years and a mean interval between the last embolization and clipping of 38.2±44.7 months (range 2–111 months). The aneurysm location was the anterior communicating artery in three cases, posterior communicating artery in one, internal carotid artery communicating segment in three, and middle cerebral artery in two. The mean aneurysm size was 10.4 mm (range 4.3–25.0 mm) and mean neck width was 3.9 mm (range 2.2–8.4 mm). The recurrence type was self-growth for five aneurysms, with a mean maximum size growth of 2.8 mm (range 2–4 mm); four were coil compactions detected on follow-up images (figures 1 and 2). For the aneurysms with coil compactions, this phenomenon was observed through imaging comparisons without detailed quantitative data analysis. Detailed information of the patients and aneurysms is shown in table 1.

#### Gross observations

Six of nine aneurysms had a preserved, intact, yellow-pink, thin wall with coils poking out of the wall and blood clots. The

### Table 1 Basic patient and recurrent aneurysm characteristics

<table>
<thead>
<tr>
<th>Aneurysm No</th>
<th>First coiling reason</th>
<th>Endovascular treatment times</th>
<th>Last implant time (months)*</th>
<th>Clipping reason</th>
<th>Location</th>
<th>Size/neck (mm)</th>
<th>Imaging findings</th>
<th>Type†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Headache</td>
<td>2</td>
<td>2</td>
<td>SAH</td>
<td>AComA</td>
<td>13.3/4.5</td>
<td>Aneurysm growth</td>
<td>III</td>
</tr>
<tr>
<td>2</td>
<td>Headache</td>
<td>2</td>
<td>2</td>
<td>SAH</td>
<td>RmCA</td>
<td>12.2/4.2</td>
<td>Aneurysm growth</td>
<td>III</td>
</tr>
<tr>
<td>3</td>
<td>SAH</td>
<td>1</td>
<td>35</td>
<td>Recurrence</td>
<td>RmCA</td>
<td>4.3/2.2</td>
<td>Coil compaction</td>
<td>IV</td>
</tr>
<tr>
<td>4</td>
<td>Dizziness</td>
<td>1</td>
<td>6</td>
<td>Recurrence</td>
<td>PComA</td>
<td>25.0/8.4</td>
<td>None</td>
<td>V</td>
</tr>
<tr>
<td>5</td>
<td>SAH</td>
<td>2</td>
<td>102</td>
<td>SAH</td>
<td>RCA C7</td>
<td>8.2/4.5</td>
<td>None</td>
<td>V</td>
</tr>
<tr>
<td>6</td>
<td>SAH</td>
<td>1</td>
<td>7</td>
<td>Recurrence</td>
<td>AComA</td>
<td>5.2/2.4</td>
<td>Aneurysm growth</td>
<td>III</td>
</tr>
<tr>
<td>7</td>
<td>SAH</td>
<td>2</td>
<td>8</td>
<td>Recurrence</td>
<td>AComA</td>
<td>5.3/2.2</td>
<td>Coil compaction</td>
<td>III</td>
</tr>
<tr>
<td>8</td>
<td>SAH</td>
<td>1</td>
<td>71</td>
<td>SAH</td>
<td>LCA C7</td>
<td>6.3/2.2</td>
<td>Aneurysm growth</td>
<td>III</td>
</tr>
<tr>
<td>9</td>
<td>SAH</td>
<td>2</td>
<td>111</td>
<td>SAH</td>
<td>LCA C7</td>
<td>13.4/4.5</td>
<td>Aneurysm growth and coil compaction</td>
<td>IV</td>
</tr>
</tbody>
</table>

* Last implant time means the interval between the last endovascular treatment and clipping.
† The type of recurrent aneurysm is classified into the following five types: I, pure recanalization inside the aneurysm sac; II, pure coil compaction without aneurysm growth; III, new aneurysm neck formed without coil compaction; IV, new aneurysm neck formed with coil compaction; and V, newly formed aneurysm neck and sac. Types I–IV can be resolved with endovascular treatment, whereas types III–V require surgical clipping.

AComA, anterior communicating artery; SAH, subarachnoid hemorrhage; LCA C7, left carotid artery communicating segment; PComA, posterior communicating artery; RCA C7, right carotid artery communicating segment; RMCA, right middle cerebral artery.
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buck of the coils was packaged by the thrombus and aneurysm wall. The neck remnant cavity could be clearly observed, and the neck tissue was thicker than the dome. (figures 1 and 2D). For the other three aneurysms, only incomplete specimens were obtained because the tissue was partly damaged during surgery. Therefore, only the thrombus and coils could be observed.

Histologic findings

The three types of thrombus found in most aneurysms were fresh, unorganized, and stable. (1) A fresh thrombus was seen in the aneurysm dome where incomplete embolization left empty space within the aneurysm sac. The thrombus consisted of erythrocytes and a small number of macrophages around the fibrillar collagen, with no thrombus attached to the coils. (2) Unorganized and unstable thrombi were located near the empty neck, and were gradually organizing into granulation tissue. (3) Stable thrombi comprised complete scar tissue located in the middle of the sac, close to the aneurysm wall. These were mature thrombi with a layer of endothelial cells formed on the surface (ie, re-endothelialized), and were tightly connected to the coils. Inflammatory cells, including neutrophils, hemosiderin macrophages, and lymphocytes, had infiltrated the aneurysm sac (figure 1E–G). The inflammatory cell infiltration of the wall was also seen on H&E staining.

In the ruptured aneurysm specimens, H&E staining showed serum effusion and necrotic cells with stained vacuoles, indicating bleeding in this area. One unfibrosed thrombus was loosely linked with the coils in the center of the section. Except for this thrombus, the other thrombi were composed of transforming scar tissue, with no cells but only necrotic collagen fibers. The inflammatory reaction was similar to the description in the previous paragraph (figure 2E–G). Compared with the unruptured aneurysm specimens, the ruptured specimens had more fresh thrombi and less endothelial lining of the aneurysm wall.

Masson staining resulted in blue-purple coloring surrounding the packing coils in the aneurysm sac, which represented mature and organized thrombi with collagen and mature granulation tissue. The stain was still unsatisfactory after two attempts.

Immunohistochemical staining was performed on one aneurysm using CD68 and smooth muscle actin (SMA) antibodies. Macrophages were distributed throughout the whole vascular wall, especially in the outer layer. SMA staining showed the discontinuity of smooth muscle cells (SMCs) in the middle media layer. The infiltration of inflammatory cells was more severe in areas with less SMA staining, where the inflammatory cells included macrophages and lymphocytes in the aneurysm wall (figure 3A,B).

DISCUSSION

Coil insertion quickly changes the intra-aneurysm blood flow and decreases the aneurysm mural pressure to reduce the lumen blood flow velocity, contributing to thrombosis embolization and ultimately leading to aneurysm occlusion. However, aneurysm recurrence after embolization treatment is still very common in clinical practice. We conducted pathological studies on recurrent aneurysms after endovascular therapy and obtained some important findings. The intra-aneurysm thrombosis showed some interesting distribution features after coiling, and granulation tissue was found in the neck of the recurrent aneurysms.

In the histopathological analysis, all thrombus stages were observed in the recurrent aneurysm sac. This finding suggests
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Figure 2  Case 8, patient in their 50s with an aneurysm located at LC7. (A) Digital subtraction angiography reveals complete aneurysm occlusion in LC7 (open arrow). (B) Head CT angiography shows aneurysm recanalization with obvious aneurysm growth (open arrow). (C) Head CT shows subarachnoid hemorrhage from the aneurysm (linear high signal in the basal cistern and longitudinal fissure, patchy heterogeneous high signal shadow in the left frontal base, low signal ring around). (D) Gross specimen with the coils protruding from the aneurysm wall (open arrow). (E–G) Microscopic section (hematoxylin-eosin stain, magnification ×5 and ×12.5) showing a fresh thrombus loosely linked with coils (open arrow) and surrounding serum effusion and necrotic collagen fibers (arrow).

that the fresh thrombus gradually turned into scar tissue in the process of thrombus organization. All three types of thrombus found in the present study (fresh thrombus, unstable granulation tissue, and scar tissue) have been described in previous publications. Previous studies of autopsy pathology sections have showed that the fresh thrombus is loosely filled with coils at
invasive imaging detection of thro...continue and incomplete middle layer in specimens immunohisto-

One important pathological finding was the granulation tissue in the residual cavity at the aneurysm neck. The thrombus was still unorganized without epithelialization. Previous examination of IA autopsy sections has shown that after successful endovascular coil embolization, the vascularized connective tissue completely fills the aneurysm cavity and embeds the coils, and the aneurysm neck is completely covered by a layer of long slender cells, suggesting endothelium. Our pathological results of recurrent post-embolic aneurysms were different from those of stable post-embolic aneurysms. Inadequate neck thrombus fibrosis may be an important indicator of aneurysm recanalization after embolization, and this pathological characteristic in the aneurysmal neck at a certain time after embolization may predict the final treatment outcome. Furthermore, during the operation, we found that this empty cavity was also the site where blood flow continuously impinged into the aneurysm neck. This indicates that the lack of endothelialization may be associated with the empty cavity in the aneurysm neck. A lack of sufficient endothelialization to protect the unorganized thrombus in the aneurysm sac may result in post-embolic aneurysm recurrence. Previous studies have used gadolinium-enhanced 7T MRI to analyze the aneurysm microstructures, including the thrombus and aneurysm wall. Furthermore, the pathological results of the aneurysm sac thrombus treated by bare platinum coils are correlated with an abnormal signal on 7T MRI in an animal model. Non-invasive imaging detection of thrombi may help in the diagnosis of recurrent IAs in the future.

Our immunohistochemical staining results provided evidence to suggest that the mechanism of IA recurrence is impairment of the SMCs and infiltration of inflammatory cells. The discontinued and incomplete middle layer in specimens immunohistochemically stained for SMA suggests the impairment of SMCs. Marbacher et al. found that thrombus organization is significantly dependent on the presence of healthy SMCs in an animal aneurysm model. Similarly, SMC impairment may contribute to the recurrence of human aneurysms, but the detailed and complex mechanisms are unclear. In our study, the integrity and continuity of SMA staining was poorer in regions with more significant macrophage infiltration, suggesting that inflammatory cells may injure the SMCs. This phenomenon was also found in a previous animal study, which reported that the macrophage infiltration resulted in apoptosis of the SMCs in interleukin-1β-deficient mice. Furthermore, both H&E and CD68 + staining showed the presence of lymphocytes and macrophages in the recurrent aneurysm wall, suggesting persistent chronic inflammation in the wall. The infiltration of inflammatory cells is the basic reaction of coil implantation therapy. Based on the current evidence, the specific role of inflammatory cells in complete aneurysm embolization remains controversial.

In the present study, the mean recurrent aneurysm size was 10.4 mm and the mean neck width was 3.9 mm. Furthermore, the most common aneurysm recurrence types were self-growth and coil compaction. The basic characteristics of aneurysms affect the outcome of endovascular treatment, with higher rates of recurrence reported for aneurysms with a wide neck and large size. These imaging characteristics play a role in aneurysm recurrence, and the detailed correction procedures required have been investigated.

To explain the phenomenon of aneurysm rupture after coiling, we propose two explanations based on (1) the imaging findings of three self-growth aneurysms after coiling, (2) the intraoperative observation of coils projecting at the rupture site, and (3) the histopathological findings. The first explanation is that the aneurysm growth results in thinning of the aneurysm wall and insufficient stress or tension to maintain its own geometric structure. Pathologically, these types of aneurysm have a more unorganized thrombus and less endothelialization to resist blood impingement than other aneurysms, which eventually leads to aneurysm recurrence and rupture. The second explanation is the formation of a pseudocapsule at the rupture point after the first bleeding episode, so that the wall of the pseudocapsule is much thinner and more prone to rupture at the same site. The specific aneurysm re-rupture mechanism after endovascular therapy still needs further research.

LIMITATIONS
This study had some limitations. Because the specimens were collected from living humans, some aneurysm necks could not be completely obtained. Additionally, in this study, we lacked sufficient cases of unruptured aneurysms so that we were unable to compare the histopathology and morphology of unruptured and ruptured aneurysms. Furthermore, as we did not investigate the corresponding mechanisms, we cannot explain whether inflammation and SMCs directly or indirectly affect the recurrence process.

CONCLUSION
The nine recurrent aneurysm specimens had particular histopathological features. The coexistence of three types of thrombi is their main characteristic. The formation of stable thrombus may be one of the key points of aneurysm recurrence. Furthermore, SMC damage and infiltration of inflammatory cells in the aneurysm wall probably contribute to the recanalization.

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Contributors CW cleaned and analyzed the data; drafted and revised the paper. XY, HC, ML revised the paper. YZ wrote the statistical analysis plan, cleaned and analyzed the data, and revised the paper. DZ designed data collection tools, monitored data collection for the whole trial, and revised the paper.

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