Central Venous Reflux, a Rare Cause of Neurological Manifestations in Hemodialysis Patients: A Case Report and Literature Review

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INTRODUCTION

Central venous disease (CVD) is a serious complication in hemodialysis patients. Neurological manifestations are rare. We describe a female with end-stage renal disease with throbbing headache accompanied by paresthesia, weakness, and abnormal posture of her right hand during dialysis sessions. Motor symptoms completely resolved after each dialysis session, although the headaches persisted for several hours. No neurological deficit was evidenced on physical examination. Digital subtraction angiography identified an incomplete thrombosis of the left brachiocephalic vein with retrograde flow in the internal jugular vein, sigmoid sinus, and transverse sinus on the left side. This case illustrates that cerebral venous congestion due to CVD can produce neurological symptoms. Furthermore, we systematically review the literature to identify the characteristics of the cases described so far. This allows clinicians to know the entity and have a high index of suspicion in a hemodialysis patient who develops neurological symptoms.

Key Words: Neurologic manifestations; Renal dialysis; Venous thrombosis; Catheterization, central venous; Vascular access devices

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botic occlusion of the left BCV. We also performed a systematic review of the literature.

**CASE REPORT**

A 51-year-old female presented with a 3-month duration of throbbing headache, of moderate to severe intensity, located in the frontal and retroocular region, without nausea or vomiting. It got worse during dialysis sessions and interfered with her activities of daily living. She also complained of paresthesia, weakness, and abnormal posture of her right hand during headache episodes. Motor symptoms completely resolved after each dialysis session, although the headaches persisted for several hours. No neurological deficit was evidenced on physical examination. Her past medical history includes arterial hypertension and chronic renal failure secondary to focal segmental glomerulosclerosis. Six years ago, she had a deceased donor kidney transplant. Due to the rejection of the transplant, she required hemodialysis through a central venous catheter (CVC) in the right IJV for 7 months. Then, an arteriovenous fistula (AVF) was performed in her left upper limb, and she undergoes hemodialysis through this access until now.

Brain tomography and magnetic resonance imaging did not show acute lesions or signs of intracranial hypertension (optic nerve sheath hydrops, reduced pituitary height, optic disc protrusion, or optic nerve edema). The fundus examination was normal. Magnetic resonance angiography showed high signal intensities of the sigmoid sinus, transverse sinus, and inferior petrosal sinus on the left side due to venous reflux (Fig. 1A–D). Digital subtraction angiography (DSA) ruled out intracranial AVF and identified an incomplete thrombosis (75%) of the left BCV (Fig. 1E). Delayed venous phase images of DSA showed reverse venous flow in the IJV, sigmoid sinus, and transverse sinus on the left side (Fig. 1F). The patient was not eligible for endovascular treatment due to the difficulty of making a new venous access. The decision was to start anticoagulation with complete resolution of symptoms after 3 months of follow-up.

**DISCUSSION**

We described a hemodialysis patient who developed neurological symptoms due to thrombotic occlusion of the left BCV. The estimated incidence of CVD in patients undergoing hemodialysis ranges from 16% to 50%. However, the presence of neurological symptoms is rare and nonspecific. In Table 1, we summarize the cases of neurological manifestations secondary to CVD reported so far. There is no sex prevalence with a mean age of 55.4 years (standard deviation (SD) ±14.1). Cardiovascular risk factors were identified in 14 out of 23 patients, with arterial hypertension being the most frequent factor (50%), and the average time of hemodialysis was 7.1 years (SD ±3.4).

The etiology of CVD is multifactorial. However, CVC placement has been associated with an increased risk of CVD, even after its removal. SCV access has up to 4 times the risk compared to IJV for the development of this pathology. As well as our patient, CVC placement was described in 6 out of 23 of the reported cases.

In patients without a history of endoluminal devices, hemodynamic abnormalities could explain the development of CVD. Turbulent blood flow due to the presence of AVF would damage the vessel wall, stimulate the development of neointimal hyperplasia, and cause stenosis. Shunts located on the left side are associated with an increased risk of stenosis or thrombosis due to anatomical causes (left BCV is located between the sternum and pulsating aorta, which contributes to stenosis).

Among the reported cases, 14 patients (60.9%) had an AVF, 7 (30.4%) had an arteriovenous graft, and in 2 cases (8.7%) the type of shunt was not specified. The mean time from AVF creation to symptoms onset was 4.5 years (SD ±4.2), and in 65.2% of patients (15/23), including the present case, the shunt was located in the left upper limb.

Previous studies have found associations between venous reflux and neurological manifestations. Retrograde flow caused by CVD (especially BCV) could cause alteration of the cerebral venous drainage, affect the circulation of the cerebrospinal fluid, and develop intracranial hypertension. Headache attacks in our patient could be explained by this mechanism. On the other hand, intracranial venous congestion decreases cerebral perfusion pressure, which leads to a reduced supply of brain nutrients and potentially causes a hypoxia-like condition and affects neuronal function. This is some of the currently available evidence about the pathophysiology of central venous reflux as a cause of neurological signs and symptoms. Among the patients described, occlusion/thrombosis prevailed over stenosis as a more frequent central lesion, and in the majority of them (87%) there was...
BCV involvement. The most frequent symptoms and signs were: headache (60.9%), motor deficits (21.7%), cranial nerve involvement (17.4%), and sensory symptoms (4.3%).

Change of flow direction could also lead to increased cerebral venous pressure, causing ischemia (due to altered cerebral perfusion pressure) or bleeding. A brain lesion was present in 30.1% of reported cases at symptoms onset, which included 3 cerebral infarctions and 3 intraparenchymal hemorrages. We did not identify brain lesions in our case.

The diagnosis of CVD is based on clinical and imaging findings. A high index of suspicion is necessary for this pathology, where DSA is the gold standard for the diagnosis of this disease due to its greater sensitivity compared to other imaging methods.  

Symptoms can be reversible if CVD is treated early. Treatment options include percutaneous transluminal angioplasty (PTA), stenting, and surgery. PTA with a dilatation balloon is the current mainstay of treatment and should be performed

![Fig. 1](https://doi.org/10.5469/neuroint.2021.00444)

**(A)** Brain time-of-flight (TOF) magnetic resonance angiography (MRA) shows reflux venous flow in the sigmoid sinus, transverse sinus (white arrow), and inferior petrosal sinus (arrowhead) on the left side. **(B)** Brain TOF magnetic resonance venography shows reflux venous signals in the left transverse sinus (white arrow). **(C, D)** Neck TOF MRA demonstrates retrograde flow in the left internal jugular vein (IJV) (white arrow). **(E)** Digital subtraction angiography (DSA) after injection in the left brachial artery shows reflux venous flow in the left IJV (white arrow) and incomplete thrombosis of the left brachiocephalic vein (black arrow). **(F)** Delayed venous phase images of DSA show retrograde flow in the IJV, sigmoid sinus (white arrow), and transverse sinus (black arrow) on the left side.
Table 1. Existing case reports of neurological complications due to central venous disease in hemodialysis patients

<table>
<thead>
<tr>
<th>Study</th>
<th>Sex/age (y)</th>
<th>Length of HD (y)</th>
<th>Previous CVC</th>
<th>CVC location</th>
<th>Previous renal transplant</th>
<th>AV shunt type/limb</th>
<th>Shunt usage time</th>
<th>Neurological manifestations</th>
<th>Central venous disease</th>
<th>Treatment</th>
<th>Evolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lal et al. (1986)</td>
<td>M/62</td>
<td>3</td>
<td>Yes</td>
<td>Right SCV</td>
<td>No</td>
<td>AVF/right upper limb</td>
<td>1 year</td>
<td>Decreased visual acuity, diplopia, retro-ocular throbbing headache, transient amaurosis</td>
<td>Right BCV stenosis</td>
<td>AVF ligation</td>
<td>Complete resolution of symptoms in 6 weeks</td>
</tr>
<tr>
<td>Molina et al. (1998)</td>
<td>M/74</td>
<td>5</td>
<td>Yes</td>
<td>Right and left SCV, right IJV</td>
<td>No</td>
<td>AVF and AVG/bilateral</td>
<td>6 months</td>
<td>Decreased visual acuity, headache, blurry vision</td>
<td>Bilateral BCV stenosis</td>
<td>AVF ligation</td>
<td>Complete resolution of symptoms</td>
</tr>
<tr>
<td>Varelas et al. (1999)</td>
<td>F/58</td>
<td>NR</td>
<td>Yes</td>
<td>Right SCV</td>
<td>No</td>
<td>AVF/right upper limb</td>
<td>NR</td>
<td>Diplopia, right hemispheric headache, bilateral sixth nerve palsy</td>
<td>Right BCV stenosis</td>
<td>Angioplasty + stent placement</td>
<td>Resolution of ophthalmoplegia in 24 hours</td>
</tr>
<tr>
<td>Hartman et al. (2001)</td>
<td>F/59</td>
<td>8</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>AVF/left upper limb</td>
<td>5 years</td>
<td>Headache, gait disturbance, memory loss</td>
<td>Left BCV stenosis</td>
<td>AVF ligation</td>
<td>Resolution of hydrocephalus and symptoms in one week</td>
</tr>
<tr>
<td>Chang et al. (2004)</td>
<td>F/50</td>
<td>3</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>3 years</td>
<td>Intermittent headache, retro-ocular pressure</td>
<td>Left BCV stenosis</td>
<td>Balloon angioplasty</td>
<td>Resolution of symptoms and papilledema in 3 months</td>
</tr>
<tr>
<td>Cuadra et al. (2005)</td>
<td>F/57</td>
<td>NR</td>
<td>Yes</td>
<td>NR</td>
<td>Yes</td>
<td>AVG/right upper limb</td>
<td>NR</td>
<td>Headache, blurry vision</td>
<td>Right JUV, SCV, and axillary vein stenosis</td>
<td>AVG occlusion</td>
<td>Visual acuity was not recovered in the left eye</td>
</tr>
<tr>
<td>Nishimoto et al. (2005)</td>
<td>F/62</td>
<td>9</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>9 years</td>
<td>Headache, seizures</td>
<td>Left BCV thrombosis</td>
<td>AVF ligation</td>
<td>Immediate resolution</td>
</tr>
<tr>
<td>Cleper et al. (2007)</td>
<td>F/13</td>
<td>10.5</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>AVF/left upper limb</td>
<td>2 months</td>
<td>Right amaurosis, seizures</td>
<td>Right BCV and SCV occlusion</td>
<td>AVF ligation and creation of new access failed</td>
<td>The patient died</td>
</tr>
<tr>
<td>Watson and Russo (2007)</td>
<td>F/36</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>NR</td>
<td>Headache, blurry vision</td>
<td>Left BCV occlusion</td>
<td>Recanalization of the left BCV</td>
<td>Complete resolution of symptoms</td>
</tr>
<tr>
<td>Nishijima et al. (2011)</td>
<td>F/47</td>
<td>5</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>5 years</td>
<td>Right hemiplegia, headache, seizures</td>
<td>Left BCV occlusion</td>
<td>AVF ligation</td>
<td>Dramatic recovery from motor deficit</td>
</tr>
<tr>
<td>Saha et al. (2012)</td>
<td>F/53</td>
<td>3</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVG/left upper limb</td>
<td>NR</td>
<td>Headache, lethargy</td>
<td>Left IJV stenosis</td>
<td>AVG occlusion</td>
<td>Complete resolution of symptoms</td>
</tr>
<tr>
<td>Samaniego et al. (2013)</td>
<td>M/50</td>
<td>11</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVG/right upper limb</td>
<td>2 weeks</td>
<td>Headache, left homonymous hemianopia, encephalopathy</td>
<td>Left BCV occlusion</td>
<td>AVG occlusion</td>
<td>Full recovery one week later</td>
</tr>
<tr>
<td>Study</td>
<td>Sex/age (y)</td>
<td>Length of HD (y)</td>
<td>Previous CVC location</td>
<td>Previous renal transplant</td>
<td>AV shunt type/limb</td>
<td>Shunt usage time</td>
<td>Neurological manifestations</td>
<td>Central venous disease</td>
<td>Treatment</td>
<td>Evolution</td>
<td></td>
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<tr>
<td>Herzig et al. (2013)³</td>
<td>M/73</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>NR</td>
<td>Headache, blurry vision, seizures</td>
<td>Left BCV thrombosis</td>
<td>AVF ligation</td>
<td>Full recovery 2 days later</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F/67</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>NR</td>
<td>Right arm monoparesis, involuntary movements of the right arm</td>
<td>Left BCV stenosis</td>
<td>Angioplasty + stent placement, Recanalization of the stent</td>
<td>Incomplete recovery with recurrence at seven months, Complete recovery four months after the second intervention</td>
<td></td>
</tr>
<tr>
<td>Salama et al. (2014)⁴</td>
<td>F/40</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/left upper limb</td>
<td>NR</td>
<td>Tinnitus, proptosis of the left eye</td>
<td>Left BCV occlusion</td>
<td>Angioplasty + stent placement</td>
<td>Recovery of symptoms in 24 hours</td>
<td></td>
</tr>
<tr>
<td>Prasad et al. (2015)²</td>
<td>M/47</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVG/ left upper limb</td>
<td>NR</td>
<td>Right hemiparesis, altered mental status</td>
<td>Left BCV occlusion</td>
<td>Angioplasty + stent placement</td>
<td>Recovery of symptoms in the following days</td>
<td></td>
</tr>
<tr>
<td>Simon et al. (2014)¹⁹</td>
<td>M/65</td>
<td>NR</td>
<td>Yes</td>
<td>Right IJV</td>
<td>No</td>
<td>AVF/Bilateral</td>
<td>Decreased visual acuity, headache, blurry vision, tinnitus</td>
<td>Right BCV thrombosis</td>
<td>Angioplasty</td>
<td>Headache recovery in 24 hours. Visual acuity improved at 5 months</td>
<td></td>
</tr>
<tr>
<td>Mackay and Biousse (2015)⁹</td>
<td>F/60</td>
<td>NR</td>
<td>NR</td>
<td>No</td>
<td>AVF/right upper limb AVG/left upper limb AVG NR AVG 3 days</td>
<td>Headache, blurry vision</td>
<td>Right SCV stenosis</td>
<td>Withdrawal of AVG. Ventriculoperitoneal shunt</td>
<td>Complete resolution of symptoms in 4 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kim et al. (2018)⁸</td>
<td>F/71</td>
<td>7</td>
<td>NR</td>
<td>No</td>
<td>AVG/ left upper limb AVG/ left upper limb</td>
<td>7 years</td>
<td>Throbbing headache</td>
<td>Left BCV occlusion</td>
<td>Balloon angioplasty</td>
<td>Complete resolution of symptoms The patient died</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F/63</td>
<td>10</td>
<td>NR</td>
<td>No</td>
<td>AVG/ left upper limb AVG/ left upper limb</td>
<td>10 years</td>
<td>Seizures</td>
<td>Left BCV occlusion</td>
<td>Delayed treatment for sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haruma et al. (2020)¹¹</td>
<td>M/53</td>
<td>4</td>
<td>NR</td>
<td>No</td>
<td>AVF/ left upper limb</td>
<td>4 years</td>
<td>Right hemiparesis, altered mental status, seizures</td>
<td>Left BCV stenosis</td>
<td>Angioplasty + stent placement</td>
<td>Symptom improvement without recurrence of stenosis</td>
<td></td>
</tr>
<tr>
<td>Iguchi et al. (2020)³⁰</td>
<td>F/73</td>
<td>14</td>
<td>NR</td>
<td>Yes</td>
<td>AVF/ left upper limb</td>
<td>NR</td>
<td>Aphasia</td>
<td>Left BCV stenosis</td>
<td>AVG occlusion</td>
<td>Complete resolution of symptoms in one month</td>
<td></td>
</tr>
<tr>
<td>Caiza-Zambrano et al. (current study)</td>
<td>F/43</td>
<td>8</td>
<td>Yes</td>
<td>Right IJV</td>
<td>Yes</td>
<td>AVF/ left upper limb</td>
<td>5 years</td>
<td>Abnormal right hand posture, retro-ocular headache, paresthesia</td>
<td>Incomplete left BCV thrombosis</td>
<td>OAC</td>
<td>Complete resolution of symptoms in three months</td>
</tr>
</tbody>
</table>

M, male; F, female; HD, hemodialysis; CVC, central venous catheter; SCV, subclavian vein; IJV, internal jugular vein; BCV, brachiocephalic vein; AV, arteriovenous; AVF, arteriovenous fistula; AVG, arteriovenous graft; NR, not reported; OAC, oral anticoagulants.
only if there is a clinical indication (arm or face swelling). Balloon dilation for a narrow lesion found incidentally without symptoms accelerates the growth of the lesion. All the current treatment options will lead to recurrent stenosis or occlusion requiring multiple repeat interventions to maintain patency, but the risk of vessel rupture may increase.

Other options may be decongestion of the cerebral venous system by closing the active vascular access, but an alternative vascular access should be insured to continue renal replacement therapy. Ligation/occlusion was performed in half of the reported patients, and less frequently (39.1%) when they underwent PTA. Twenty patients had good outcomes with a disappearance or clear improvement of symptoms after treatment.

Due to the location and type of lesion, our patient was not eligible for endovascular treatment. AVF ligation was not possible because the patient did not have another adequate venous access for a new AVF placement. Our patient represents the first reported case of neurologic manifestations secondary to CVD with complete resolution of symptoms after oral anticoagulants therapy. We have no evidence about medical therapy for secondary prevention for CVD. Further randomized controlled trials of currently available treatment options with long-term follow-up are essential in the future to develop adequate treatment algorithms.

Central venous reflux due to CVD is a serious complication in patients undergoing hemodialysis. Neurological manifestations are infrequent; therefore, this entity requires a high index of suspicion in those patients under hemodialysis who present neurological symptoms. Moreover, anticoagulation could be considered as an alternative treatment in special cases.

**Author Contributions**
Concept and design: FCZ, CMP, SG, and PB. Analysis and interpretation: FMG, MBB, MF, and MS. Data collection: FMG, MBB, FL, MF, and MS. Writing the article: FCZ, CMP, SG, and PB. Critical revision of the article: SG, CR, RR, and MFP. Final approval of the article: CR, RR, MFP, and PB. Statistical analysis: FL and MF.

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**REFERENCES**

**Fund**
None.

**Ethics Statement**
This case report was approved by the Institutional Review Board (British Hospital Institutional Bioethics Committee) and conducted according to the criteria set by the declaration of Helsinki. Written informed consent for publication of her details was obtained from the patient.

**Conflicts of Interest**
The authors have no conflicts to disclose.
Caiza-Zambrano F et al. Neurological Manifestations due to Central Venous Reflux


