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Review

Autopsy approach to stroke

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Abstract

Stroke is a major cause of morbidity and mortality but the brain and other relevant tissues are often examined only cursorily when stroke patients come to autopsy. The pathological findings and clinical implications vary according to the type of stroke, its location and cause. Large ischaemic strokes are usually associated with atherosclerosis of extracranial or major intracranial arteries but can be caused by dissection. Most small cerebral infarcts are caused by arteriosclerosis or, in the elderly, cerebral amyloid angiopathy (CAA). However, vasculitides and coagulopathies can cause a range of different patterns of ischaemic (and, occasionally, haemorrhagic) stroke. Global brain ischaemia, caused by severe hypotension or raised intracranial pressure, produces damage that is accentuated in certain regions and neuronal populations and may be confused with hypoglycaemic injury. The main cause of subarachnoid haemorrhage is a ruptured berry aneurysm but CAA, arteriovenous malformations and infective aneurysms are occasionally responsible. These can also cause parenchymal brain haemorrhage, although this most often complicates hypertensive small vessel disease. Sometimes the haemorrhage arises from a neoplasm. Performing an adequate autopsy in stroke requires proper preparation, awareness of the likely pathological processes, familiarity with intracranial vascular anatomy, careful gross examination and dissection, and appropriate use of histology.

Keywords: stroke, brain infarct, brain ischaemia, brain haemorrhage, vasculopathy, vasculitis, vascular malformation, thrombophilia

Introduction

The term stroke describes the sudden loss of neurological function that results from blockage or rupture of a blood vessel supplying the brain or spinal cord. Approximately 80% of strokes are due to cerebral infarction (see below). Stroke is a major cause of morbidity and mortality. In most parts of the world it is the second or third commonest cause of death (accounting for about 7-10%) after cardiac disease and cancer. Of survivors, about 30% die within 1 year and over 50% within 6 years; in general, most survivors will have impaired vocational capacity, about 30% will need help in caring for themselves and about 15% will require institutional care.

The annual risk of having a stroke more than doubles every decade over the age of 55,¹ increasing from about 1-2 per 1000 between 45 and 54 years of age to 11-13 per 1000 in the over-75s. In some groups (e.g. American Indians) the risk is more than double that in the wider population. Although the data indicate that stroke is a major healthcare challenge, it is worth noting that in much of the developed world the incidence has declined over several decades; the reasons are not fully understood but improved recognition and control of hypertension, and reductions in cigarette smoking are probably contributory factors.

Scope of this review

Although strokes are a major cause of death and disability, the brain and other relevant tissues are often examined only cursorily when stroke patients come to autopsy. This is a disservice to their next-of-kin, the clinicians responsible for their assessment and care, and society in general, as findings of genetic or medicolegal relevance are missed, standards of

clinicopathological correlation and audit are debased, and opportunities for teaching and research are lost.

The aim of this review is to provide basic guidance to pathologists undertaking the post-mortem examination of stroke patients. It includes an overview of the causes and types of stroke, their pathological features and an approach to their post-mortem investigation. It does not deal with haemorrhagic and hypoxic-ischaemic brain damage in the neonate or with the molecular pathogenesis of ischaemic or haemorrhagic brain damage, complex topics that are extensively covered in reference books and more-focused reviews.¹⁻⁴ Whilst the present review refers to some types of vascular pathology that are occasionally a result of trauma, it does not cover extradural and subdural haemorrhage, which mainly result from trauma and are more appropriately considered in that context. Finally, the main focus of this article is the pathology of cerebrovascular disease and the conduct of the autopsy after stroke-related death; although there is some reference to clinical features and genetic aspects of stroke these are not described in any detail.

Causes of stroke

Vasculopathies and vasculitides

The vasculopathies and vasculitides can be broadly subdivided into diseases of large and small vessels (Table 1). These diseases can manifest in several ways, the most common of which is infarction. In the case of thrombosis of a large artery supplying blood to the brain or spinal cord, the infarct typically conforms to the corresponding arterial perfusion territory (Fig 1). Thrombosis of small arteries and arterioles produces small, so-called lacunar infarcts (Fig 2); because most small vessel diseases are generalised or at least

multifocal within the central nervous system, these lacunar infarcts tend to be multiple and to involve multiple arterial perfusion territories.

Large atherosclerotic arteries (usually extracranial) may act as sources of embolism of thrombus or atheromatous material. Less often, thromboembolism complicates arteritis or berry aneurysms. Embolic occlusion typically involves multiple small arteries within the perfusion territory of the originating vessel and causes multifocal infarction, often haemorrhagic.

Two types of small vessel disease, arteriosclerosis/arteriolosclerosis and A β -cerebral amyloid angiopathy (A β -CAA) are the commonest causes of parenchymal brain haemorrhage. Arteriosclerosis/arteriolosclerosis-related haemorrhage tends to be deep-seated within the brain (involving the basal ganglia, thalamus, pons or cerebellum) and to rupture into the ventricular system. CAA-related haemorrhage tends to occur within the cerebral cortex and superficial white matter and may extend into (or occur within) the subarachnoid space. In CAA, the risk of haemorrhage is increased by the development of 'vasculopathic' complications, particularly concentric splitting of the vessel wall or fibrinoid necrosis (Fig 3). Rarely CAA is associated with a surrounding lymphocytic infiltrate⁵ or complicated by a vasculitis in which a destructive inflammatory reaction, usually granulomatous, is centred on A β deposits in the vessel walls (A β -related angiitis).⁶ CAA can also be complicated by thrombosis, and carries an increased risk of microinfarcts.⁷

Arterial dissection (Fig 4) is largely a disease of large vessels – the carotid artery, its proximal branches and the vertebral arteries – although smaller intracranial arteries can be affected. Most patients have a history of recent blunt trauma or hyperextension of the neck but the 'trauma' may be mild (e.g. chiropractic manipulation of the neck) and

vertebral or internal carotid dissection sometimes occurs without an identifiable precipitating event. Extracranial dissections tend to produce arterial occlusion and infarction, and intracranial dissections subarachnoid haemorrhage.

The commonest type of aneurysm affecting the CNS is the berry (saccular) aneurysm, present in 2-5% of adults. These aneurysms almost always involve branch points of the major intracranial arteries (Fig 5) and the majority involve the anterior part of the circle of Willis (i.e. the proximal branch points or junctions of the internal carotid, middle cerebral, anterior cerebral and anterior communicating arteries). The major clinical complication is rupture and consequent haemorrhage; this is usually into the subarachnoid space and often associated with retrograde spread of blood into the ventricles but sometimes the fundus of the aneurysm is partly embedded in the adjacent brain and rupture produces an intraparenchymal haemorrhage. Atherosclerotic aneurysms are much less common than berry aneurysms and usually occur in the vertebrobasilar region; they may be complicated by thrombosis and/or embolism but rupture is rare. In a minority of patients, atherosclerotic, dissecting or berry aneurysms (see below) present with neurological deficits resulting from compression of adjacent cranial nerves, arteries or brain structures by the abnormally dilated blood vessel.

Bacterial vasculitis usually occurs in the context of septicaemia with or without endocarditis and septic emboli (Fig 6), and fungal vasculitis in the context of immunodeficiency. Both can involve large basal arteries but more often affect small arteries, arterioles and venules. Infective vasculitis tends to cause thrombosis and infarction but can also cause weakening, aneurysmal dilatation and rupture of the vessel wall, with resulting subarachnoid or parenchymal brain haemorrhage. Because infective

aneurysms are mostly small and embedded in thrombus they can rarely be identified macroscopically; their diagnosis usually requires histological assessment.

Embolism

The commonest types of CNS embolism are thrombotic and atheromatous, as described above. Septic emboli are also considered above, in the context of infective vasculitis and aneurysms. Other types of cerebrovascular embolism include fat embolism, therapeutic embolism and a few much rarer entities (e.g. air embolism, embolism of tumour tissue or of intervertebral disc material). In most of these cases the embolic material occludes multiple arterioles and capillaries in internal carotid artery distribution, and the pathological presentation is with scattered small foci of haemorrhage and infarction, predominantly in the cerebral white matter and centred on small blood vessels that may be necrotic. After a few days the red blood cells are phagocytosed and removed and the picture becomes one of scattered microinfarcts, some containing small amounts of haemosiderin. Fat embolism is seen mainly in patients who have sustained multiple traumatic injuries that include fractures of long bones. Patients with cerebral fat embolism usually have clinical, radiological and pathological evidence of pulmonary fat embolism as well but this is not always the case. The lipid remains demonstrable for several days in frozen sections through the affected white matter (Fig 7).

Impaired coagulation

Much the most common coagulopathy in stroke patients is the acquired impairment of γ -carboxylation and activation of the coagulation factors II, VII, IX, and X caused by

administration of warfarin.^{8,9} This accounts for 5-25% of haemorrhagic strokes. About 70% are intracerebral, the remainder subdural. The risk increases with intensity of anticoagulation, age and with previous cerebral ischaemic events. The risk of haemorrhagic stroke is also increased by intravenous tissue plasminogen activator (tPA).

Impaired platelet function

Although in some studies antiplatelet agents such as aspirin and clopidogrel have been associated with a slightly increased incidence or severity of cerebral haemorrhage, other studies have not confirmed these findings.⁸⁻¹⁰

Thrombophilia

There are multiple acquired and inherited diseases that predispose to clotting of the blood.¹¹ Most are associated predominantly with venous occlusion but the more severe forms of thrombophilia also cause arterial thrombosis and infarction. The most common of the thrombophilias is the acquired antiphospholipid syndrome,¹² in which patients (most often female) experience episodes of vascular thrombosis and/or unexplained fetal death in association with the presence of medium to high titres of anticardiolipin antibodies. Patients may experience arterial thrombosis, venous thrombosis or a combination of the two, leading to arterial infarcts (usually lacunar) and venous infarcts and haemorrhages.

Thrombotic thrombocytopenic purpura (TTP) is characterised clinically by the combination thrombocytopenia, neurological abnormalities, microangiopathic haemolytic anaemia, fever, and renal failure. It may be idiopathic (associated with antibody-mediated inhibition of the metalloprotease ADAMTS13, which normally cleaves the prothrombotic

von Willebrand factor) or a complication of pregnancy, certain medications and diseases (e.g. human immunodeficiency virus infection). The neurological abnormalities are caused by occlusion of multiple small vessels by platelet and fibrin thrombi (Fig 8).

Cerebral venous sinus thrombosis

This is uncommon but probably also under-diagnosed. Risk factors include a range of local and systemic conditions. The most common local risk factors are infection – involving either the middle ear and mastoid bone or the paranasal sinuses, with spread to the overlying dura – and cranial trauma. Others include local surgical procedures and, rarely, tumours.

Systemic risk factors include pregnancy and the puerperium, antiphospholipid syndrome (see above) and other causes of thrombophilia (protein C or S deficiency, factor V Leiden, antithrombin deficiency, etc), polycythaemia rubra vera, severe dehydration, nephritic syndrome and Behçet's disease. The risk is slightly increased with oral contraceptive use.

The thrombus tends to propagate along the venous sinuses and major veins draining the cerebral convexities and deep grey matter, to produce extensively infarction and haemorrhage in the corresponding venous territories (Fig 9).

Vascular malformations

Arteriovenous malformation (AVM)

These are present in about 15-20 per 100,000 adults^{13, 14} and carry a risk of rupture and symptomatic haemorrhage of about 2-6% per annum,^{15, 16} depending on size, whether or

not the AVM has bled previously, and ethnic factors (e.g. in a Californian study the risk was higher in Hispanics than in other ethnic groups).¹⁶ AVMs consist of an interconnected network of arteries, veins and abnormal blood vessels (Fig 10), including large veins with irregularly thickened, fibrotic walls and ecstatic thin-walled vascular channels that have a prominent internal elastic lamina but little or no tunica media. Some vessels may be thrombosed or calcified. The vessels are partly separated by brain parenchyma that is often gliotic and may show evidence of previous haemorrhage or ischaemic damage. Many AVMs involve the leptomeninges as well as the underlying brain tissue. In 5-10% of patients with AVMs, saccular aneurysms develop on the feeding arteries. Arterial aneurysms can also occur within the AVM itself.

In infants a distinct subtype of AVM occasionally occurs, in which there is shunting occurs between one or more enlarged choroidal or thalamic arteries and the great vein of Galen. Because the affected blood vessels usually dilate markedly the AVM is sometimes called an 'aneurysm' of the vein of Galen. The massive shunting of cardiac output that tends to occur through these AVMs can cause high-output cardiac failure. Other complication includes obstructive hydrocephalus, intracranial haemorrhage and ischaemic brain damage.

In hereditary hemorrhagic telangiectasia (HHT; Osler-Weber-Rendu disease), capillary telangiectases involving the skin and mucosae are associated with AVMs of internal organs, including the CNS (affected in ~10% of patients).¹⁷ At least five genetic subtypes exist (including HHT associated with juvenile polyposis), all autosomal dominant. Neurological complications include haemorrhage from cerebral AVMs and consequences of pulmonary AVMs (embolism, ischaemic stroke and cerebral abscess).

Dural arteriovenous fistula (including Foix-Alajouanine syndrome)

Dural arteriovenous fistulae (dAVFs) most often occur within nerve root sleeves, between thoracic or upper lumbar spinal radicular arteries and veins communicating with the paraspinal valveless venous plexus¹⁸. Cervical dAVFs are much less common and intracranial dAVFs rare. Typically spinal dAVFs present in adulthood with slowly progressive myelopathy accompanied by striking dilatation and tortuosity of the venous plexus over the dorsum of the cord. The walls of the veins become markedly thickened and fibrotic (Fig 11). Small vessels within the cord also show fibrous thickening of their walls (sometimes to the extent of obliteration of the central lumen) and over time the surrounding parenchyma becomes depleted of neurons, gliotic and cavitated.

Cavernous haemangioma (cavernoma)

These are present in about 0.5% of people¹⁹ and are composed of numerous thin-walled vascular channels, lined by endothelium surrounded by collagenous connective tissue, with no internal elastic lamina or tunica media (Fig 12). Most of the channels abut one another with no intervening brain parenchyma. About 75% are supratentorial and 25% infratentorial. Many cavernomas remain asymptomatic but over half eventually manifest with headaches, seizures, neurological deficits or brain haemorrhage. About 20% of cases of cavernoma are familial, with autosomal dominant transmission.^{20, 21} The proportion of familial cases is higher in Hispanic Americans of Mexican descent.²² To date four genetic loci for cavernoma have been identified (one not yet fully characterised). Over 50% of patients with familial cavernomas have multiple lesions; fewer than 20% of those with sporadic cavernomas.¹⁹

Venous angioma

Venous angioma (or developmental venous anomaly) is the most common cerebrovascular malformation.²³ It consists of clusters of enlarged venous channels, usually separated by normal brain tissue. They are usually asymptomatic but venous infarction, haemorrhage and seizures are rare complications. About 25% occur in the vicinity of a cavernous haemangioma (see above) and a smaller proportion are involve the venous drainage of AVMs (see above) and these two forms of associated vascular malformation may be the true source of many of the clinical manifestations attributed to venous angiomas.²³

Capillary telangiectasia

This comprises clusters of dilated capillaries with normal intervening tissue. Capillary telangiectases most often involve the pons but can occur in any part of the brain and are of similar prevalence to cavernous haemangiomas but hardly ever manifest clinically.

Neuropathological findings: brain ischaemia

Disease of large arteries

Atherothrombotic narrowing or occlusion of major intracranial or extracranial cerebral arteries accounts for around 10-30% of symptomatic cerebral infarcts (the figure varies with ethnicity)²⁴⁻²⁶. The infarct is usually of large volume, occupying much of the perfusion territory of the affected artery (Fig 1). However, depending on the extent of collateral supply of blood from adjacent arteries, the infarct may be predominantly subpial, deep or even sited along part of the boundary zone of the perfusion territory of the affected artery.²⁷

Disease of small arteries

Occlusion of small arteries and arterioles is the main cause of lacunar infarcts (infarcts measuring up to about 10mm in diameter). Pathological examination reveals multiple small foci of cavitated infarction and ischaemic damage (see Selective cell damage, below) involving multiple arterial territories (Fig 2). These are usually associated with widespread arteriosclerosis and arteriolosclerosis, particularly in the cerebral white matter and deep grey matter structures; enlargement of perivascular spaces in these regions; tortuosity and occasional microaneurysmal dilatation of arterioles; and very occasional fibrinoid necrosis or thrombosis. Some of the infarcts may contain haemosiderin-laden macrophages and in practice it is sometimes difficult to distinguish lacunar infarcts from old microhaemorrhages.

Small lacunar infarcts may also complicate CAA and vasculitis. A further, rare cause of lacunar infarcts and ischaemic degeneration of the white matter and deep grey matter is CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy), caused by mutations of *NOTCH3* and associated with extracellular accumulation of granular material along the plasmalemma of vascular smooth muscle cells (which eventually degenerate), particularly in the brain (Fig 13).

Changes in infarcted brain tissue over time

The macroscopic and histological changes that infarcts undergo with time have been extensively described in many reference texts on neuropathology^{1, 28} and will be summarised here only briefly. Over the first 24 hours the infarcted grey matter becomes increasingly congested, changing from a light greyish tan colour to a dusky reddish brown

(Fig 1). It may include foci of petechial haemorrhage. The white matter also darkens and becomes congested but the changes are usually quite subtle and it is difficult to discern the edges of the infarct clearly until about 2 days. By this time the infarcted tissue is obviously softer than the adjacent parenchyma and at about 2-3 days may separate from it during post-mortem handling of the brain ('cracking artefact'). Over subsequent days and weeks the infarct undergoes liquefactive necrosis and then cavitation.

Histology reveals a fairly stereotyped sequence of morphological changes in neurons and glia.²⁹ By about 4-6 hours many neurons in the infarcted tissue appear shrunken with pyknotic nuclei, perineuronal glia have swollen, clear cytoplasm, and there may be diffuse microvacuolation of the neuropil (Fig 14). Between about 6 and 48 hours more and more of the neurons develop cytoplasmic hypereosinophilia. Their nuclei become less pyknotic and increasingly amphophilic or eosinophilic and by 2-3 days although neuronal outlines are still well defined many of the nuclei are difficult to distinguish from the surrounding cytoplasm. Glia too, particularly oligodendrocytes in the white matter and perineuronal satellite cells in the grey matter, show initial nuclear pyknosis but over the next 2-3 days many undergo apoptosis rather than necrosis, and clusters of apoptotic bodies may be seen in the infarcted tissue, away from blood vessels, sometimes abutting neurons. Vascular endothelial cells initially swell but those in the central region of the infarct later show nuclear pyknosis and undergo apoptosis.

By 6-12 hours blood vessels towards the edge of the infarcted tissue are margined by neutrophils and scattered neutrophils are visible in the surrounding tissue. Between 1 and 2 days the inflammatory infiltrate increases but mononuclear cells predominate. Foamy macrophages accumulate within the tissue and around blood vessels. Endothelial

cells proliferate in the vessels along the edge of the infarct and vascular buds grow into the necrotic tissue. Fibroblasts may also be identified but are not nearly as prominent as in organising infarcts outside of the CNS. After several months the infarct has been transformed into a cavity containing sparse strands of glial and vascular tissue and some remaining foamy macrophages. The surrounding parenchyma contains numerous reactive and fibrous astrocytes and scattered macrophages that contain lipid debris. Some may contain haemosiderin pigment.

Selective loss of neurons after ischaemia

Neurons are more susceptible than ischaemia than are glia or blood vessels. Focal ischaemia that is brief or incomplete can cause selective death of neurons with relative preservation of other tissue elements. In such cases the ischaemic damage is marked by focal loss of neurons and reactive astrocytosis, only modest infiltration by macrophages and an absence of cavitation.

Global brain ischaemia

A global reduction in the supply of oxygenated blood to the brain most often occurs in the context of severe hypotension or raised intracranial pressure (ICP). The hypotension may be of cardiogenic (e.g. cardiac infarction, arrhythmia, tamponade) or peripheral vascular origin (e.g. marked blood loss, septicaemic shock). The raised ICP may be caused by a wide range of conditions, including space-occupying lesions (such as a haematoma or tumour), cranial trauma, metabolic disease, intracranial infection or inflammation, hydrocephalus and venous obstruction. Global brain ischaemia is itself a cause of brain swelling and raised

ICP. When the cerebral perfusion pressure (the difference between mean arterial pressure and intracranial pressure) falls below ~ 50 mmHg, the normal autoregulatory mechanisms that maintain cerebral blood flow at ~ 50 ml/100g fail and cell death occurs if the blood flow falls below 10-20 ml/100g.

Susceptibility to ischaemic damage varies not only between neurons and glia but also amongst different populations of neurons. Particularly vulnerable are the pyramidal neurons in the hippocampus – of these, neurons in the CA1 field are most vulnerable and those in the CA2 field least so. Other vulnerable neuronal populations are the pyramidal neurons of laminae 3 and 5 in the neocortex. Neurons in the depths of the sulci are more likely to be affected than those over the crests of the gyri. A common finding after global brain ischaemia is laminar necrosis: patchy or extensive loss of neurons from neocortical laminae 3 and 5, particularly towards the depths of sulci, associated with marked astrocytosis and, in longer-surviving cases, neovascularisation. Another population of neurons that is particularly susceptible to ischaemia is the Purkinje cells in the cerebellum.

The distribution of damage varies also with the extent of reduction and duration of global ischaemia. If the reduction in cerebral blood flow has been severe or prolonged, neuronal loss is likely to be widespread. In many cases, however, blood flow is better preserved in the central than the peripheral parts of the major arterial perfusion territories. The result is ischaemic damage that is accentuated in the watershed regions between the perfusion territories.

Ischaemia, hypoxia and hypoglycaemia

Whilst cerebral infarction is most often caused by ischaemia (ischaemic hypoxia, also known as stagnant hypoxia), it can also result from reduced oxygen in the blood without a reduction in cerebral perfusion (hypoxic hypoxia or anaemic hypoxia) or from toxins that impair the ability of the cells to use the oxygen for respiration (histotoxic hypoxia). The causes of hypoxic hypoxia include severe pulmonary disease, right-to-left shunting of blood and respiratory arrest. The main causes of infarction from anaemic and histotoxic hypoxia are carbon monoxide and cyanide poisoning respectively. For reasons that are not entirely clear, the brunt of the damage in carbon monoxide toxicity is usually borne by the dorsomedial part of the globus pallidum, which undergoes haemorrhagic infarction. Ischaemic white matter damage may be prominent in longer-term survivors.

Because neurons not only have minimal capacity for anaerobic metabolism but also store hardly any glycogen, they depend for respiration on a continuous supply of glucose as well as oxygen. The brain is therefore very vulnerable to the effects of hypoglycaemia. The most frequent cause is accidental or deliberate over-dosage by insulin or oral hypoglycaemic agents. The pathological consequences are very similar to those of global brain ischaemia in terms of the cellular changes and distribution of damage. One useful distinguishing feature is the relative preservation of Purkinje cells in hypoglycaemic compared with ischaemic damage.

Vascular dementia

A post-mortem diagnosis vascular dementia (VaD) is most readily made largely by exclusion, when examination of the brain from someone who had a clinical history of

dementia reveals no more than occasional neuritic plaques, neurofibrillary tangles largely confined to the hippocampus and inferomedial temporal neocortex; multiple infarcts and ischaemic lesions; moderate to severe arteriolosclerosis often associated with atherosclerosis; and an absence of histopathological evidence of other disease likely to cause dementia. The ischaemic lesions most consistently associated with dementia are multiple lacunar infarcts in combination with ischaemic white matter degeneration (Fig 2) but occasionally the principal finding is larger infarcts in critical grey matter structures (e.g. bilateral thalamic or hippocampal infarcts). Much more difficult to assess is the significance of ischaemic vascular disease in a patient who also had evidence of another dementing illness, e.g. extensive plaques and neurofibrillary tangles or neocortical Lewy bodies. In this case the diagnosis is usually expressed in terms of the likelihood that the vascular disease (or other, neurodegenerative process) may have contributed to the patient's dementia.

Neuropathological findings: haemorrhagic stroke

Subarachnoid haemorrhage

The vasculopathies responsible for subarachnoid haemorrhage are described above and in Table 1. The most common cause of subarachnoid haemorrhage is rupture of a berry aneurysm (Fig 5) but cerebral amyloid angiopathy is an important cause, particularly in the elderly. Rarer causes include arteriovenous malformation, infective aneurysms and vasculitides. Cerebral contusions and lacerations are often associated with mild subarachnoid haemorrhage but major subarachnoid haemorrhage is unusual in cranial trauma; amongst the causes to consider are vertebral artery tear or dissection near the

point of entry of the artery into the posterior fossa (Fig 4), dissection of the carotid artery and tearing of the brain stem at the junction of the pons and medulla (a pontomedullary rent).

The distribution of the subarachnoid blood may provide a clue as to the source of the haemorrhage but can be misleading, particularly in the case of a ruptured berry aneurysm. Retrograde flow of blood into the ventricles is common after subarachnoid haemorrhage. However, particularly after cranial trauma the possibility should always be considered that the blood may have originated within the periventricular tissue or choroid plexus and spread into the subarachnoid space rather than vice versa.

Parenchymal brain haemorrhage

The most common context in which parenchymal brain haemorrhage occurs is small artery disease associated with hypertension. The changes to the vessels themselves are similar to those associated with lacunar infarcts (collagenous thickening of the vessel walls, enlargement of perivascular spaces, tortuosity and occasional microaneurysmal dilatation of arterioles, and very occasional fibrinoid necrosis). The haematoma is usually large and deep-seated within the brain, causing disruption of the basal ganglia, thalamus and internal capsule, often with rupture into the ventricles. Other sites of predilection include the base of the pons and deep cerebellar tissue (in both cases usually associated with rupture into the fourth ventricle).

Other common causes of parenchymal brain haemorrhage are thromboembolism, CAA (mainly in the elderly), vascular malformations, coagulopathies, trauma and neoplasms. Rarer causes include vasculitides affecting small vessels. Much the most

frequent coagulopathy associated with brain haemorrhage is that resulting from warfarin but this rarely occurs unless the international normalised ratio (INR) is above 3.

Thrombolytic agents such as tissue plasminogen activator are also sometimes responsible for brain haemorrhage. Haemorrhage may arise from glial or metastatic tumours, the glial tumours most commonly implicated being glioblastomas (Fig 15) and oligodendrogliomas, and the metastatic tumours, melanomas, renal cell carcinomas and choriocarcinomas.

Although the rupture of a berry aneurysm usually produces subarachnoid haemorrhage, if the fundus of the aneurysm is embedded within the brain itself, parenchymal haemorrhage may result; the responsible aneurysm is most often at the first branch-point of the middle cerebral artery or the junction between the anterior and anterior communicating arteries and the haematoma involves the medial part of the temporal lobes or the anterior inferomedial part of the frontal lobes.

In the event that the haemorrhage is not fatal, the blood clot is removed by macrophages over weeks to months, leaving a cavity containing residual haemosiderin-laden macrophages. The surrounding tissue is gliotic and contains newly-formed blood vessels and macrophages. At later time points it may not be possible to distinguish with certainty between an old haematoma cavity and an old haemorrhagic infarct.

Autopsy in cases of stroke

Preparation

It is important to be clear as to the role of each individual autopsy, the scope of the authorisation or consent and the expectations of the interested parties. These will vary according to the context in which the autopsy is performed. The family may want to know

why the death occurred and whether it might have been prevented or treated more effectively. They may also be concerned about potential genetic implications for other members of the family. The clinicians are likely to share these concerns but will also be interested in correlating the pathological findings with the clinical manifestations and the results of diagnostic tests. The coroner is concerned not only with when and where the death occurred but also how it occurred – as a consequence of natural disease, or a result of intervention (e.g. suicide, unlawful killing) or exposure to unnatural conditions (e.g. an occupational hazard). The police, Crown Prosecution Service and insurance companies may also be interested in how the death occurred, particularly in the event that it was not a consequence of natural disease. Last but not least, the autopsy may be performed to support teaching or research.

For death related to cerebrovascular disease as for any other autopsy, it is important to review the clinical notes, speak to the clinicians involved in looking after the patient and consider carefully the key questions requiring clinicopathological correlation. These will include the possible sites and systems involved in the disease process and the nature of the pathological abnormalities that might account for the clinical findings. Particularly in the case of cerebrovascular disease, review of the neuroradiological studies is often essential if the critical lesions are not to be missed.

Extracranial examination

This should include careful inspection of the heart and great vessels, the cervical part of the internal carotid artery and, if relevant, the intraosseous segments of the vertebral arteries.

The intraosseous segments of the vertebral arteries can be exposed *in situ* by identification

of the lower point of entry of each vertebral artery into the vertebral canal and subsequent use of bone nibblers to remove the anterior bony covering of the canal. The dissection is easier if the bodies of the cervical vertebrae are first removed by sawing parasagittally through the pedicles but this should be done with the saw blade close to the vertebral bodies themselves otherwise the blade is likely to traverse the vertebral canal and traumatise the arteries.

Intracranial examination

In case of subarachnoid haemorrhage, it is best to try to identify the source of the bleeding prior to fixation. Wash away blood and remove blood clot to expose the arteries over the base of the brain. Gently prise apart the two frontal lobes inferiorly and depress the optic chiasm slightly to expose the anterior cerebral and communicating arteries, trace the middle arteries for 3-4cm along the inferior part of the Sylvian fissures, expose the upper end of the basilar arteries and the proximal parts of the posterior cerebral and superior cerebellar arteries and the anterior inferior and posterior inferior cerebellar arteries.

In cases of subarachnoid haemorrhage associated with cranial trauma, it is particularly important to examine the vertebral arteries within the vertebral canals and where they penetrate the dura to enter the posterior fossa. Also, pay close attention to the internal carotid arteries for evidence of dissection; this is much easier to identify before than after fixation, although the confirmation of the nature of the pathological process usually requires fixation and histology.

For later demonstration of an aneurysm it is sometimes helpful to dissect the basal arteries away from the brain and to preserve them in formalin in a sealed bag or container.

Carefully dissect the vertebral and basilar arteries away from the medulla, pons and midbrain, cutting through the cerebellar and perforating arteries as the larger vessels are peeled away from brain stem. Cut the posterior cerebral arteries near the back of the midbrain, the middle cerebral arteries well beyond their first trifurcation and the anterior cerebral arteries about 1cm beyond their junction with the anterior communicating artery and carefully separate these and the posterior communicating arteries from the base of the brain, taking care to cut the small perforating arteries that pass from the larger vessels into the brain.

Remember to open the venous sinuses and to examine the cortical veins for thrombosis. In the event of venous sinus thrombosis it is important to look for adjacent infection (e.g. look for middle ear infection and mastoiditis in a patient with lateral sinus thrombosis).

If identification of a microbial pathogen is relevant, e.g. in venous sinus thrombosis associated with infection or haemorrhage associated with an infective aneurysm, small samples of the abnormal tissue should be removed with a sterile scalpel and placed in tissue culture medium (or placed in a sterile universal container and taken to a microbiology laboratory as soon as possible). It may be helpful to culture cerebrospinal fluid, which can be obtained from the interpeduncular fossa, cistern magna or from a lateral ventricle (by separating the cerebral hemispheres, inserting the needle of a syringe about 30° to the vertical through the corpus callosum and applying slight negative pressure whilst slowly withdrawing the needle).

Major vascular malformations, foci of haemorrhage and large established infarcts within the brain can usually be identified on slicing of the unfixed tissue. However,

identification of more subtle abnormalities such as acute infarcts, ischaemic white matter damage, small vascular malformations, vasculitides and cerebral amyloid angiopathy requires fixation of the brain (or at least of the affected tissue) and histology.

Sampling for histology

The sampling will depend on the clinical context and macroscopic findings. For assessment of ischaemic brain damage it should include the main watershed regions in the cerebrum and cerebellum, the hippocampi, deep grey matter structures and brain stem (Fig 16). Ideally the brain should be fixed by suspension in formalin before it is sliced and blocks taken for histology. In the event that this is not possible, it is better to take blocks slightly larger than required and to wait until after fixation before trimming them to a size suitable for paraffin embedding and histology; this minimises artefactual distortion and leads to better quality sections.

A useful technique for histological assessment of larger blood vessels is the preparation of a serial transverse blocks (Fig 17), as originally described by Beesley and Daniel.³⁰ A length of vessel of up to about 2cm is embedded intact in paraffin wax. It is removed from the final wax bath, allowed to cool and then sliced transversely with a razor blade at intervals of 2-3mm. As each slice is cut, it is placed face-down, in order, in a steel base mould into which a thin layer of wax has been poured. Once all of the slices have been placed in the mould it is briefly warmed and then allowed to cool slightly again, fixing the slices in position. The mould is then filled with molten wax and the block is allowed to harden. Each section cut from the block displays a sequential series of levels through the

vessel, enabling it to be sampled extensively in far fewer blocks and sections that would otherwise be needed.

It may be relevant to examine the middle ear (e.g. in cases of venous sinus thrombosis) or the vessels within the base of the skull (e.g. to identify an aneurysm (Fig 18), fistula or site of dissection). Other organs and tissues often need to be examined histologically to establish the nature of a vasculitic, vasculopathic or embolic process. Particular attention should be given to heart, lungs, kidneys and skin.

Most pathological abnormalities in cerebrovascular disease are obvious in sections stained with haematoxylin and eosin. Whether additional stains are needed will depend on the nature of the pathological process. Fat emboli are readily detected in cryostat sections of formalin-fixed brain tissue, by staining with oil red O. Elastin/van Gieson stain is helpful for assessment of the integrity of the internal elastic lamina of arteries and arterioles. Fibrinoid vascular necrosis can be demonstrated with phosphotungstic acid and haematoxylin, or Martius scarlet blue. Immunostains for the specific peptide or protein constituent of vascular amyloid (usually A β) is much more sensitive than tinctorial stains such as Congo red or Sirius red. There are several immunohistochemical markers of platelets (e.g. antibody to CD61) that are useful for demonstrating platelet and fibrin thrombi (e.g. in TTP) (Fig 8). Electron microscopy is helpful, even on post-mortem tissue, for diagnosis of CADASIL (Fig 13).

Conclusion

It is not difficult to perform an adequate autopsy in stroke. The requirements are simply an awareness of the possible causes and manifestations, a reasonable knowledge of the

vascular anatomy, an informed and careful approach to the gross examination and histology, and an appreciation of the potential value of the procedure to next-of-kin, clinicians and society in general.

For Peer Review

For Peer Review

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Legends for figures

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Fig 8. Thrombotic thrombocytopenic purpura. (A) Platelet and fibrin thrombus in a small blood vessel in the deep grey matter. Note too the hypertrophy of the endothelial cells, a consistent if non-specific finding. (B) Here, the platelets in another affected blood vessel have been immunolabelled for CD61.

Fig 9. Venous sinus thrombosis and venous infarction. (A) The right transverse (lateral) sinus is filled by thrombus. In contrast the left transverse sinus appears normal. (B) In this patient the thrombosis involved the superior sagittal sinus as well as major cortical veins over the right cerebral convexity. The coronal slice includes a large region of infarction and haemorrhage in the drainage territory of the affected cortical veins.

Fig 10. Arteriovenous malformation. This malformation extends through the frontal white matter and cortex into the overlying subarachnoid space. Note the large calibre and irregular contour of many of the venous channels.

Fig 11. Foix-Alajouanine syndrome. (A) Transverse sections through the thoracic and upper lumbar spinal cord in a case of Foix-Alajouanine syndrome. There is patchy softening and yellow discolouration of the cord parenchyma and multiple thick-walled vessels are present over the dorsum of the cord (arrows). (B) Large vein with a markedly thickened fibrotic wall. For comparison, see the two adjacent normal arteries (elastin van Gieson). (C) Marked collagenous thickening of small vessels within the cord. The intervening grey matter has been replaced by a loose meshwork of astrocytic processes (elastin van Gieson).

Fig 12. Cavernous haemangioma. This consists of numerous, abutting thin-walled vascular channels, lined by endothelium surrounded by collagenous connective tissue, with no internal elastic lamina or tunica media (elastin van Gieson).

Fig 13. CADASIL. (A) The tunica media of these meningeal arterioles in CADASIL is replaced by granular eosinophilic material. (B) Electron microscopic examination of a dermal arteriole reveals accumulations of granular osmiophilic material ('GOMs') in caveolar indentations in the plasmalemma of vascular smooth muscle cells. The GOMs tend to be most prominent along the abluminal surface of the smooth muscle cells (arrows).

Fig 14. Histological changes in an acute infarct. (A) Compare infarcted cortex to the left of the panel with the preserved cortex to the right, at 4 to 5 hours. The infarcted neurons appear shrunken with pyknotic nuclei. Perineuronal glia have swollen, clear cytoplasm, and there is fine microvacuolation of the neuropil. (B) By 2 days most of the neuronal nuclei have become amphophilic or eosinophilic, making them increasingly difficult to distinguish from the surrounding cytoplasm. The section includes sparsely scattered apoptotic cells that are glial or inflammatory.

Fig 15. Haemorrhage into a tumour. A bleed was the presenting manifestation of this glioblastoma. Note the rather ill-defined margins of the haematoma and the poor definition of grey and white matter structures in the inferior part of the left temporal lobe.

Fig 16. Sampling for histology. The orange, blue and green shaded areas indicate a typical set of blocks for assessment of ischaemic brain damage. Any regions of macroscopic abnormality should also be sampled.

Fig 17. Serial block embedding. (A) Bifurcation of the right external carotid artery. A clip had been placed across the origin of the internal carotid artery, to cut off the blood flow to a large, inoperable aneurysm in the cavernous sinus, and an extracranial-intracranial bypass saphenous vein graft had been inserted between the external carotid artery and the right middle cerebral artery. Unfortunately the graft thrombosed and the patient died. A

particular concern of the surgeon was the integrity of the proximal arteriovenous anastomosis. A length of vessel across the anastomosis (arrow) was embedded intact in paraffin wax, removed from the wax bath and cut transversely at 3mm intervals (red bars).

(B) The 3mm slices were placed face-down, in order (zigzag arrow), in a steel base mould, and embedded in a single paraffin block. This section shows a sequential series of levels through the anastomosis between the elastic-poor vein and the elastic rich artery. There is post-mortem blood clot in the lumen but the anastomosis is intact (elastin van Gieson).

Fig 18. Giant aneurysm of the internal carotid artery within the cavernous sinus. This expanding aneurysm was compressing multiple cranial nerves and pushing into the pituitary fossa and decision was made to insert the extracranial-intracranial bypass graft described in the legend to Fig 17.

Table 1. Major vasculopathies and vasculitides affecting the CNS

Type of vessel	Disease	Risk factors/Cause	Major sites (in relation to neurological disease)	Main pathological findings
Large vessel	Atherosclerosis	<ul style="list-style-type: none"> • Age • Hypertension • Cigarette smoking • Diabetes mellitus • Family history • Dyslipidaemias 	<ul style="list-style-type: none"> • Aortic arch • Bifurcation of carotid arteries • Origin of vertebral arteries • Basilar artery • Terminal part of internal carotid arteries 	<ul style="list-style-type: none"> • Atherosclerosis (as in vessels elsewhere) • ± Large (major arterial territory) CNS infarct • ± Embolic lesions – multifocal infarcts, often haemorrhagic • ± Aneurysmal dilatation, especially in vertebrobasilar region
	Dissection	<ul style="list-style-type: none"> • Blunt craniocervical trauma • Neck hyperextension • Atherosclerosis • Rarely, cystic medial necrosis, fibromuscular dysplasia, arteritis, inherited connective tissue diseases 	<ul style="list-style-type: none"> • Extracranial part of internal carotid artery close to skull base • Supraclinoid internal carotid artery • Intraosseous part of vertebral artery • Intracranial part of vertebral artery 	<ul style="list-style-type: none"> • Dissection associated with intramural haematoma, usually beneath the external elastic lamina but sometimes in the subintimal region or within the tunica media • ± Large (major arterial territory) CNS infarct • ± Subarachnoid haemorrhage
	Giant cell arteritis			<ul style="list-style-type: none"> • Ophthalmic artery • Carotid artery • Vertebral/basilar artery

Fibromuscular dysplasia	<ul style="list-style-type: none"> • A1-antitrypsin deficiency 	<ul style="list-style-type: none"> • Upper cervical part of internal carotid artery • Intraosseous part of vertebral artery 	<ul style="list-style-type: none"> • Segmental collagenous thickening and disorganisation of intima/tunica media/adventitia • Usually nonspecific manifestations of intermittent/postural brain stem or hemispheric ischaemia without CNS pathology but can cause major infarcts, or subarachnoid haemorrhage (when complicated by aneurysm formation)
Takayasu's arteritis	<ul style="list-style-type: none"> • Predominantly Japan 	<ul style="list-style-type: none"> • Aorta and its proximal branches 	<ul style="list-style-type: none"> • Lymphoplasmacytic inflammation involving tunica media in aortic arch with subsequent collagenous fibrosis • Usually nonspecific manifestations of intermittent/postural brain stem or hemispheric ischaemia without CNS pathology. • May be associated with upper-body or renovascular hypertensive vascular disease (complicating aortic or renal artery stenosis)
Moyamoya syndrome	<ul style="list-style-type: none"> • Commonest in (but not restricted to) Japan 	<ul style="list-style-type: none"> • Supraclinoid internal carotid artery • Proximal middle/anterior cerebral artery 	<ul style="list-style-type: none"> • Marked collagenous thickening of the intima and striking plication of the internal elastic lamina ± evidence of thrombosis and recanalisation • Very prominent dilated collateral vessels • Multifocal/widespread ischaemic cerebral damage

Berry aneurysm

- Peak detection in late middle age
- Family history
- Cigarette smoking
- Alcohol consumption
- Hypertension (associated with rupture)
- Major artery branch points
- >85% involve terminal internal carotid/ anterior communicating/ proximal middle cerebral artery
- <15% involve vertebrobasilar arteries
- Aneurysm is usually obvious once artery is exposed (best done before fixation)
- Wall shows patchy/complete loss of internal elastic lamina and tunica media
- May be scanty inflammatory infiltrate in wall, including haemosiderin-laden macrophages
- Lumen usually contains old thrombus

Small vessel Arteriosclerosis and arteriolosclerosis

- Age
- Hypertension
- Diabetes mellitus
- Deep cerebral grey matter structures
- Cerebral white matter
- Pons
- Hyaline collagenous thickening of vessel walls with narrowing of lumina
- Loss of tunica media
- Increased vascular tortuosity ± microaneurysmal outpouchings
- Enlarged perivascular spaces
- ± Fibrinoid necrosis
- ± Foci of recent/old haemorrhage, small or large
- ± Lacunar infarcts
- ± Deep white matter rarefaction and gliosis

Cerebral amyloid angiopathy (CAA)	<ul style="list-style-type: none"> • Possession of <i>APOE</i> $\epsilon 4$ is risk factor for commonest form ($A\beta$-CAA), particularly in Alzheimer's disease • Other specific genetic mutations in much rarer forms of CAA 	<ul style="list-style-type: none"> • Cerebral cortex and leptomeninges (often most severe in occipital region) • Less often cerebellar involvement 	<ul style="list-style-type: none"> • Patchy mural deposition of $A\beta$ (mainly $A\beta_{1-40}$), initially in basement membrane along outer aspect of tunica media, then around smooth muscle cells, eventually replacing media and extending through adventitia into surrounding brain parenchyma • \pm 'Vasculopathic' changes: concentric splitting of vessel wall, fibrinoid necrosis, thrombosis, microaneurysmal dilatation • \pm Small perivascular haemorrhages in cortex • \pm Circumscribed lobar parenchymal haematomas • \pm Subarachnoid haemorrhage • \pm Lacunar infarcts and ischaemic lesions in cerebral cortex(8)
Primary angitis of the CNS (PACNS)	<ul style="list-style-type: none"> • Occasionally related to varicella-zoster virus infection 	<ul style="list-style-type: none"> • Small arteries/ arterioles in leptomeninges or anywhere in CNS parenchyma 	<ul style="list-style-type: none"> • Multifocal segmental chronic inflammation adjacent to and within the vessel walls, often granulomatous, \pm fibrinoid necrosis • \pm Lacunar infarcts • \pm Small foci of parenchymal brain haemorrhage • \pm Subarachnoid haemorrhage

CAA-related inflammation and A β -related angiitis (ABRA)

- Variant of PACNS in which the inflammation is directed against A β in the vessel wall (i.e. a complication of A β -CAA)

• Cerebral cortex and leptomeninges

- Multifocal segmental chronic inflammation adjacent to and within the walls of A β -laden vessels,(5) often granulomatous and with fragments of A β in some of the macrophages and giant cells, \pm fibrinoid necrosis
- \pm Small perivascular haemorrhages in cortex
- \pm Circumscribed lobar parenchymal haematomas
- \pm Lacunar infarcts and ischaemic lesions in cerebral cortex and underlying white matter
- \pm White matter oedema (sometimes marked)
- \pm Occasionally plaque-associated clusters of microglia in cerebral cortex(6)

Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL)

- *NOTCH3* mutations

• Cerebral leptomeninges
• Cerebral white matter
• Deep cerebral grey matter structures
• Brain stem

- Small arteries and arterioles in leptomeninges and white matter show fibrosis and loss of the tunica media, which is progressively replaced by deeply eosinophilic, moderately PAS-positive granular material
- Small arteries and arterioles in other tissue (e.g. skin) show similar but much less marked changes, demonstrable by electron microscopy
- Multiple lacunar infarcts
- White matter rarefaction and gliosis

Infective
vasculitis/aneurysm

- Septicaemia
 - Endocarditis
 - Immunodeficiency (especially fungal vasculitis)
 - Meningovascular syphilis
 - Small arteries and arterioles in leptomeninges and brain parenchyma
 - Occasionally major artery at base of brain
 - Focal vessel wall necrosis, thrombosis
 - Associated infarcts/abscesses or foci of haemorrhage
 - Bacteria demonstrable by Gram stain (may be difficult to find, especially if patient has received antibiotics).
 - Fungal hyphae usually easy to see, particularly with Grocott silver impregnation or PAS stain
 - Meningovascular syphilis causes infiltration of artery wall by lymphocytes and plasma cells and later marked fibrous thickening and stenosis
-

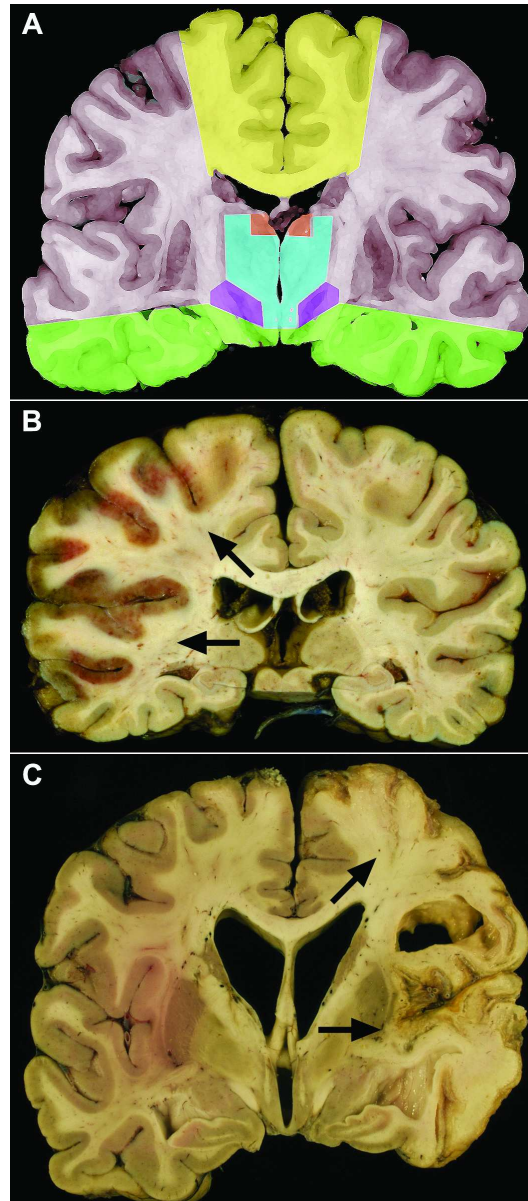


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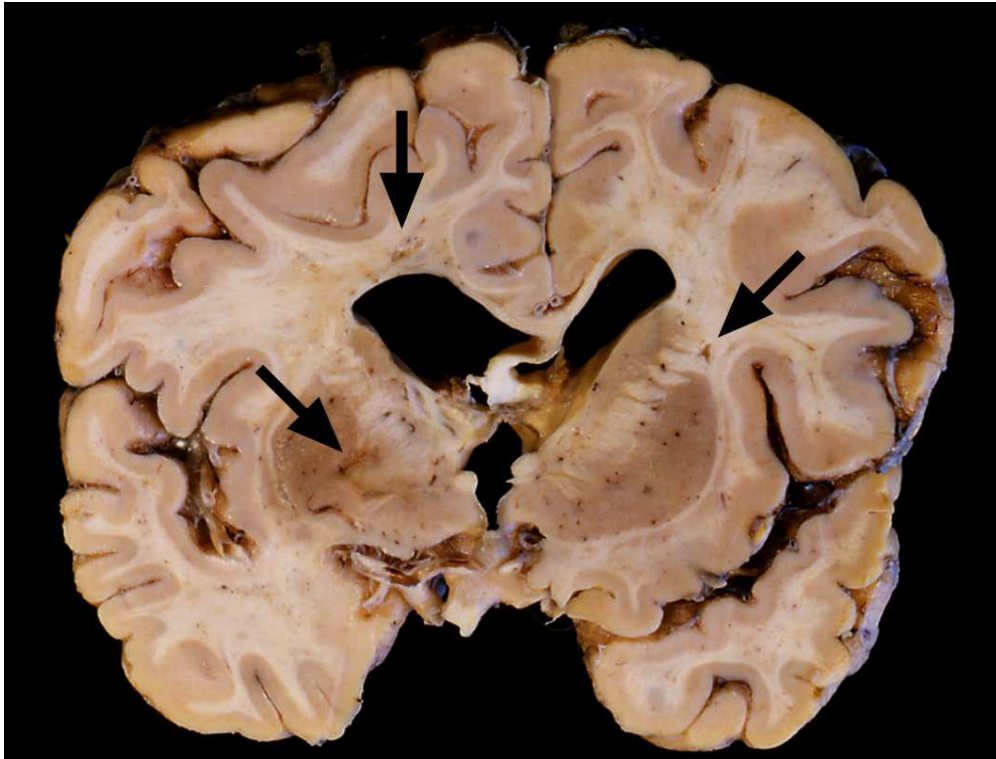


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90x68mm (300 x 300 DPI)

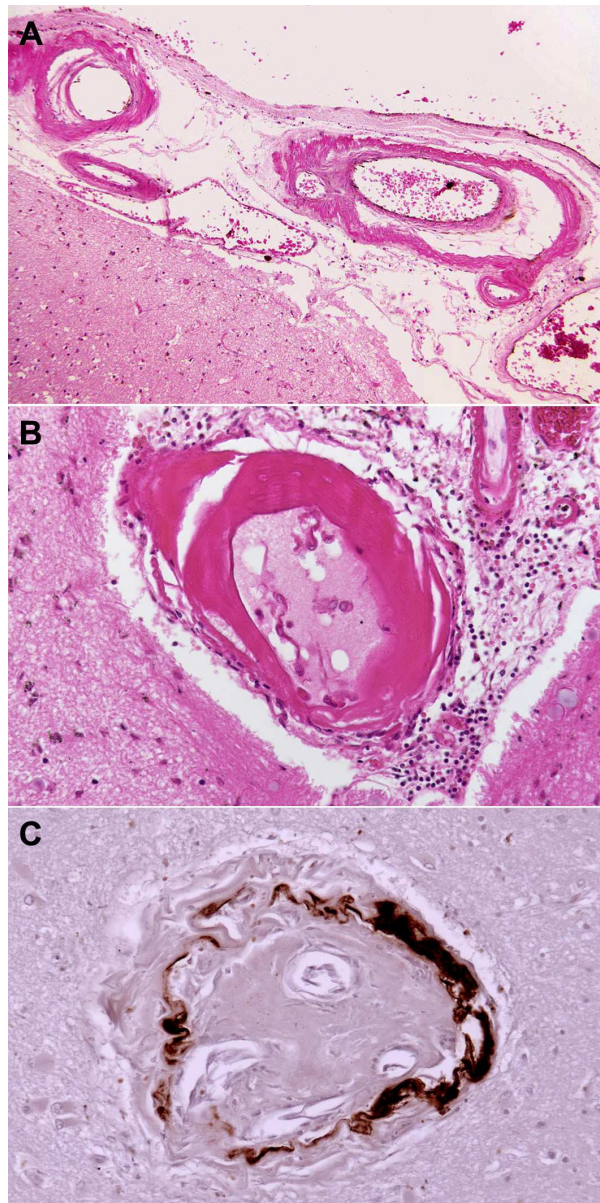


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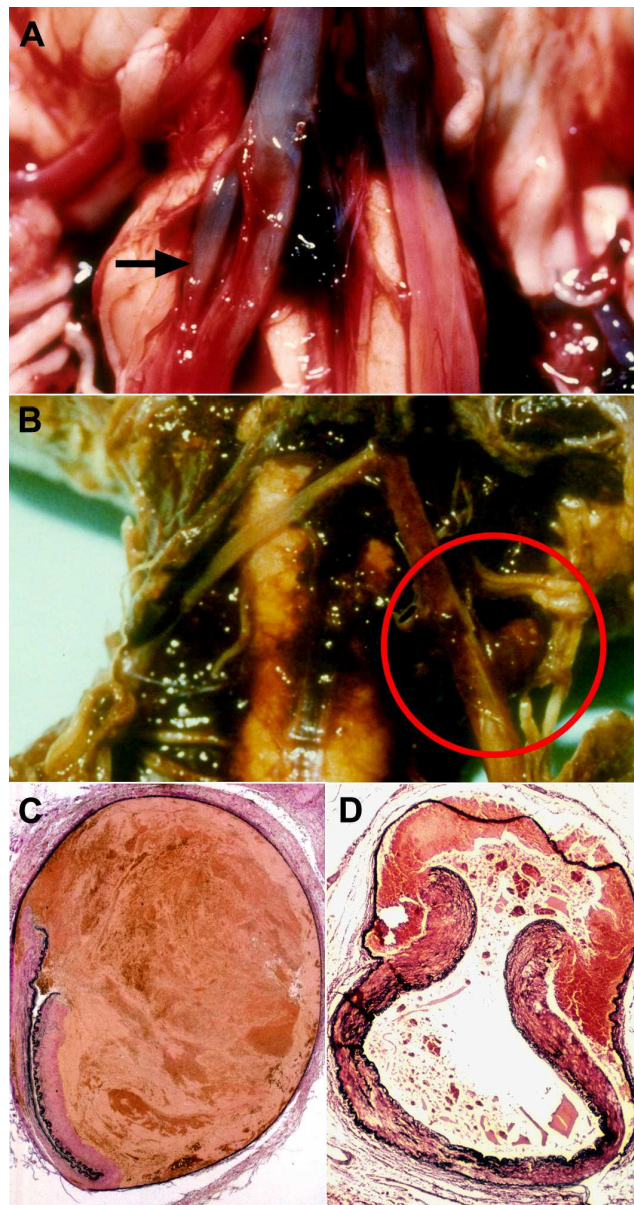


Fig 4. Traumatic arterial damage. (A) This traumatic tear (arrow) in the right vertebral artery caused massive subarachnoid haemorrhage. (B) Traumatic dissection of the left vertebral artery produced a false aneurysm (red circle), which eventually ruptured, causing subarachnoid haemorrhage. (C, D) Dissection of the internal carotid (A) and vertebral (D) arteries complicating craniocervical trauma. The sections have been stained by the elastin van Gieson method which shows very clearly the breach in the internal elastic lamina.
90x170mm (300 x 300 DPI)



Fig 5. Ruptured berry aneurysm. Some of the blood clot has been washed away to demonstrate the origin of this aneurysm (arrow) from the junction of the right internal carotid and posterior communicating arteries.
90x67mm (300 x 300 DPI)

view

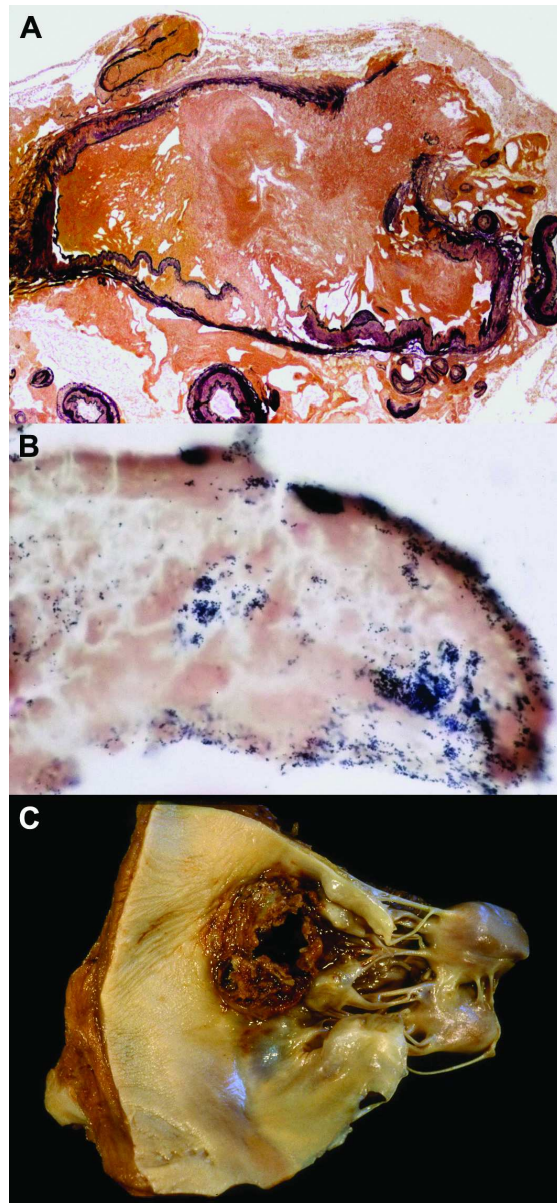


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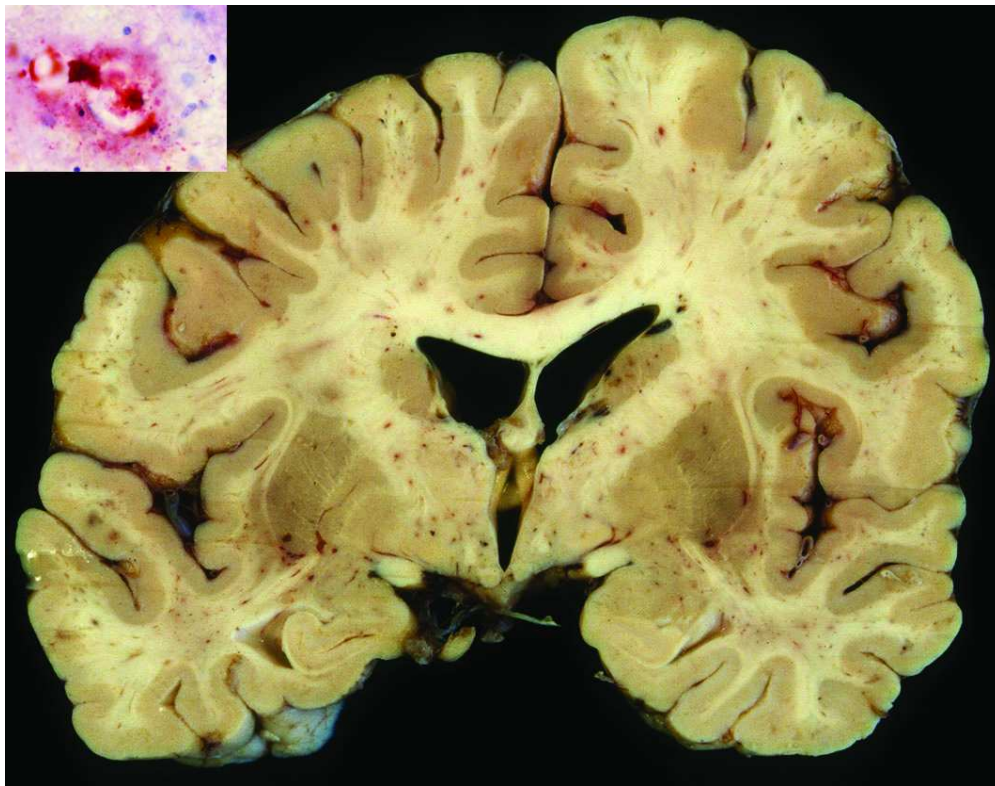


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90x70mm (300 x 300 DPI)

NEW

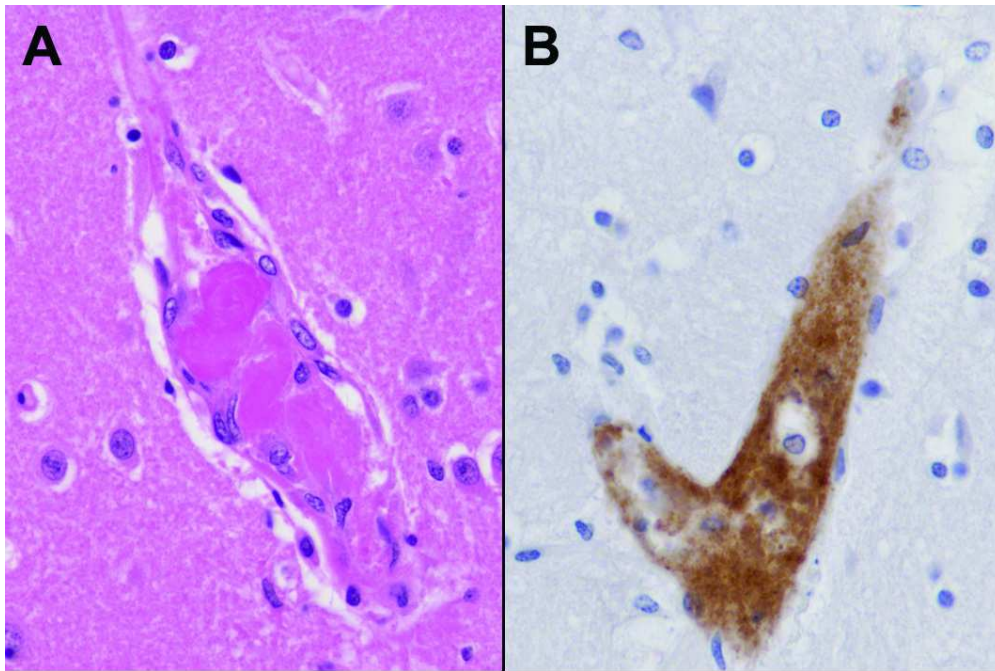


Fig 8. Thrombotic thrombocytopenic purpura. (A) Platelet and fibrin thrombus in a small blood vessel in the deep grey matter. Note too the hypertrophy of the endothelial cells, a consistent if non-specific finding. (B) Here, the platelets in another affected blood vessel have been immunolabelled for CD61.
90x60mm (300 x 300 DPI)

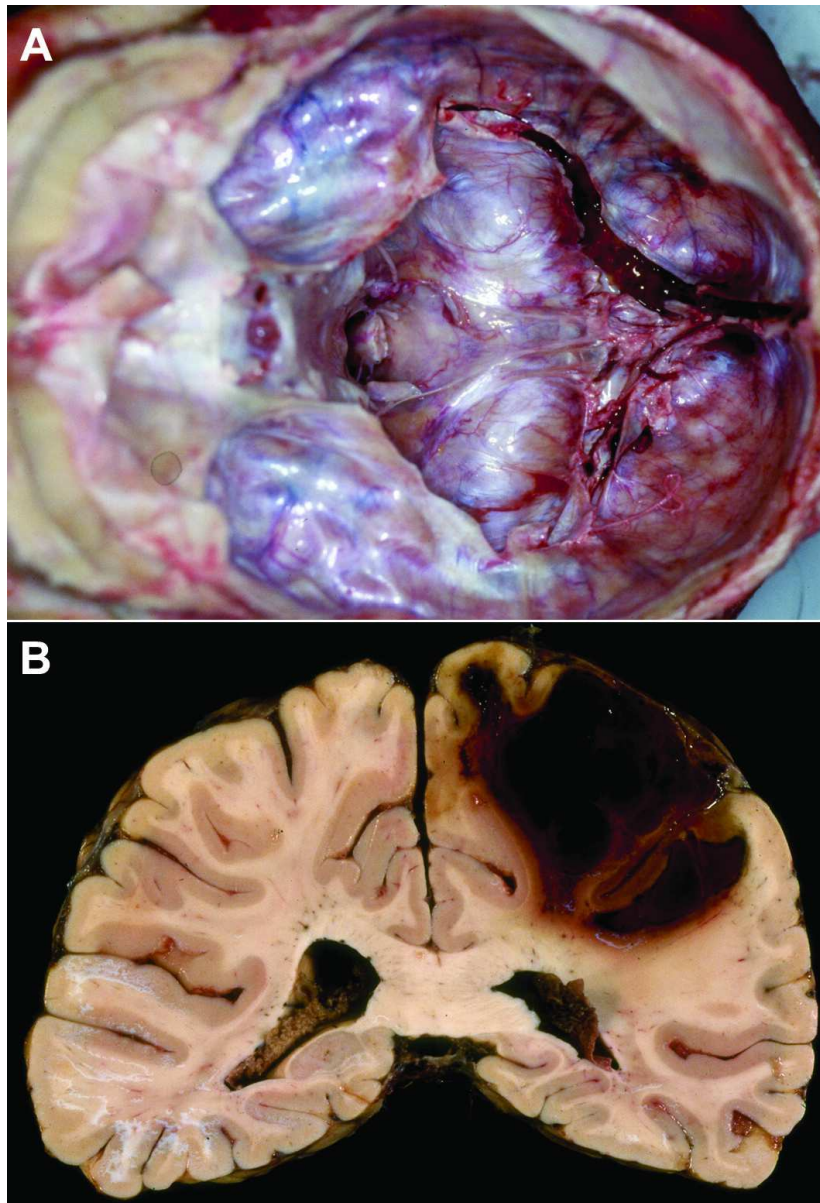


Fig 9. Venous sinus thrombosis and venous infarction. (A) The right transverse (lateral) sinus is filled by thrombus. In contrast the left transverse sinus appears normal. (B) In this patient the thrombosis involved the superior sagittal sinus as well as major cortical veins over the right cerebral convexity. The coronal slice includes a large region of infarction and haemorrhage in the drainage territory of the affected cortical veins.
90x131mm (300 x 300 DPI)

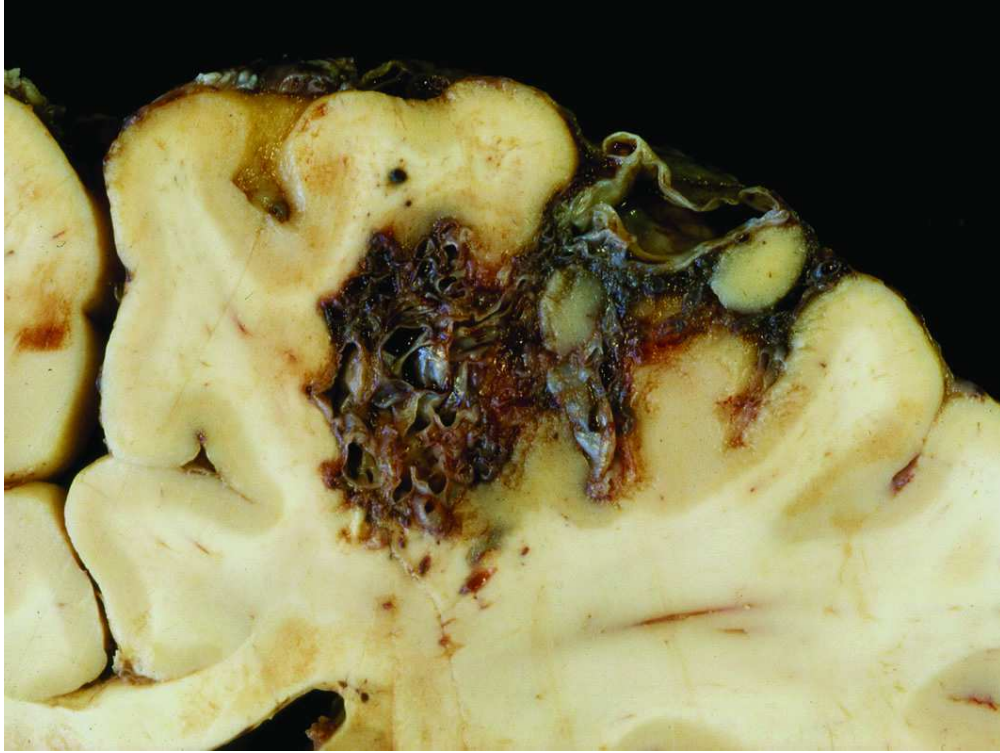


Fig 10. Arteriovenous malformation. This malformation extends through the frontal white matter and cortex into the overlying subarachnoid space. Note the large calibre and irregular contour of many of the venous channels.
90x67mm (300 x 300 DPI)

view

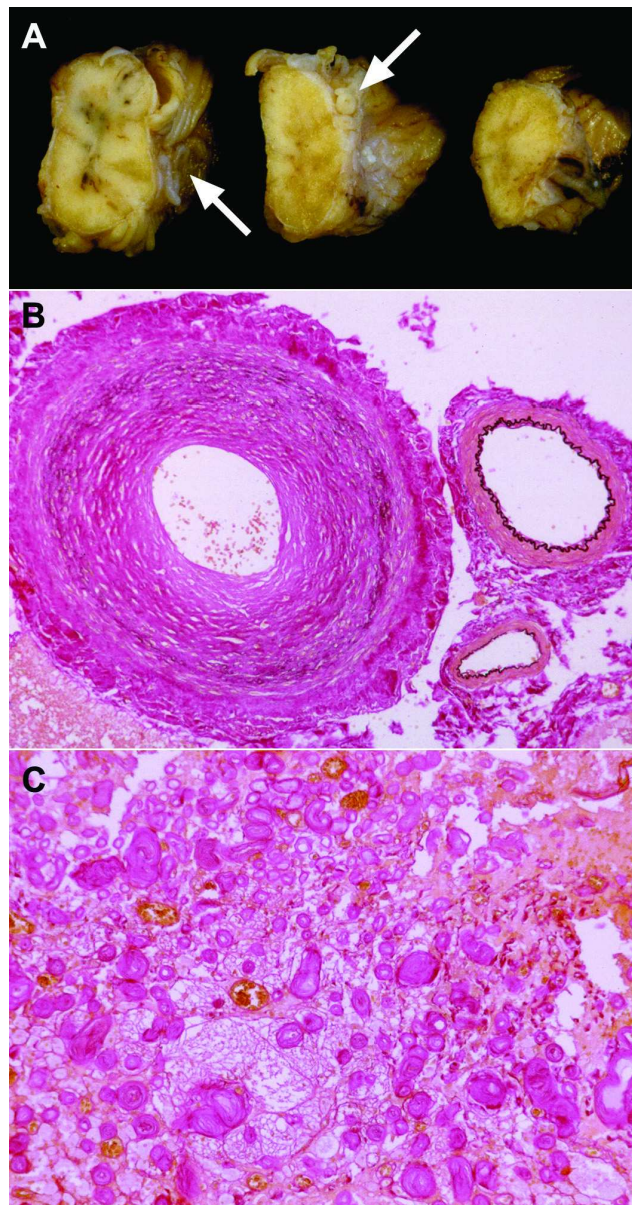


Fig 11. Foix-Alajouanine syndrome. (A) Transverse sections through the thoracic and upper lumbar spinal cord in a case of Foix-Alajouanine syndrome. There is patchy softening and yellow discoloration of the cord parenchyma and multiple thick-walled vessels are present over the dorsum of the cord (arrows). (B) Large vein with a markedly thickened fibrotic wall. For comparison, see the two adjacent normal arteries (elastin van Gieson). (C) Marked collagenous thickening of small vessels within the cord. The intervening grey matter has been replaced by a loose meshwork of astrocytic processes (elastin van Gieson).
90x170mm (300 x 300 DPI)

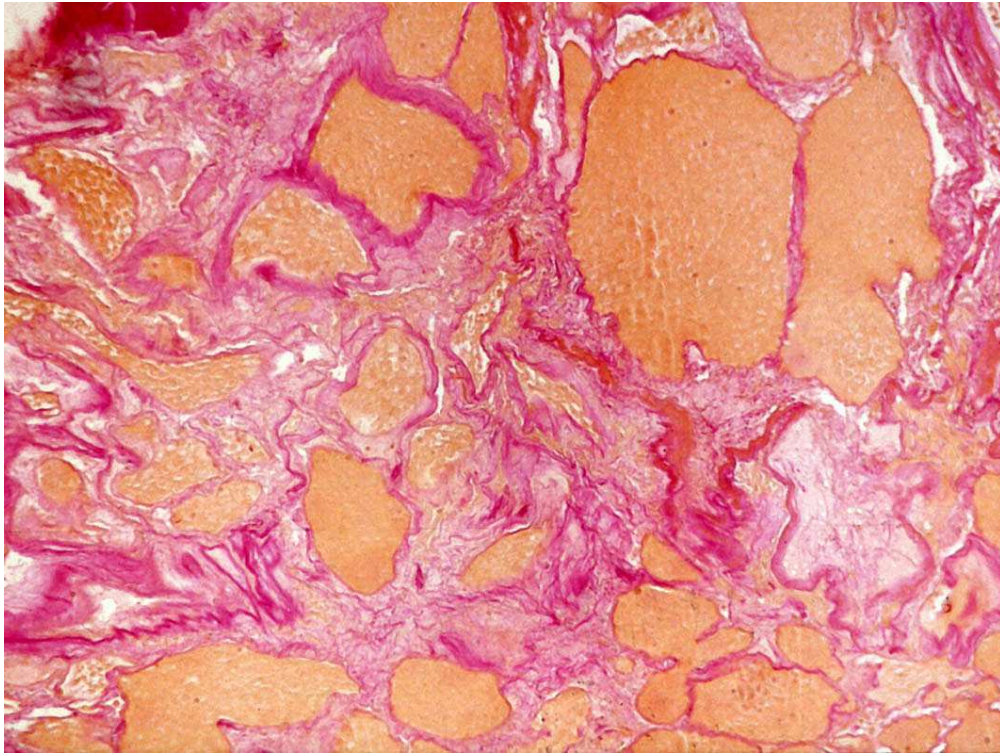


Fig 12. Cavernous haemangioma. This consists of numerous, abutting thin-walled vascular channels, lined by endothelium surrounded by collagenous connective tissue, with no internal elastic lamina or tunica media (elastin van Gieson).
90x67mm (300 x 300 DPI)

view

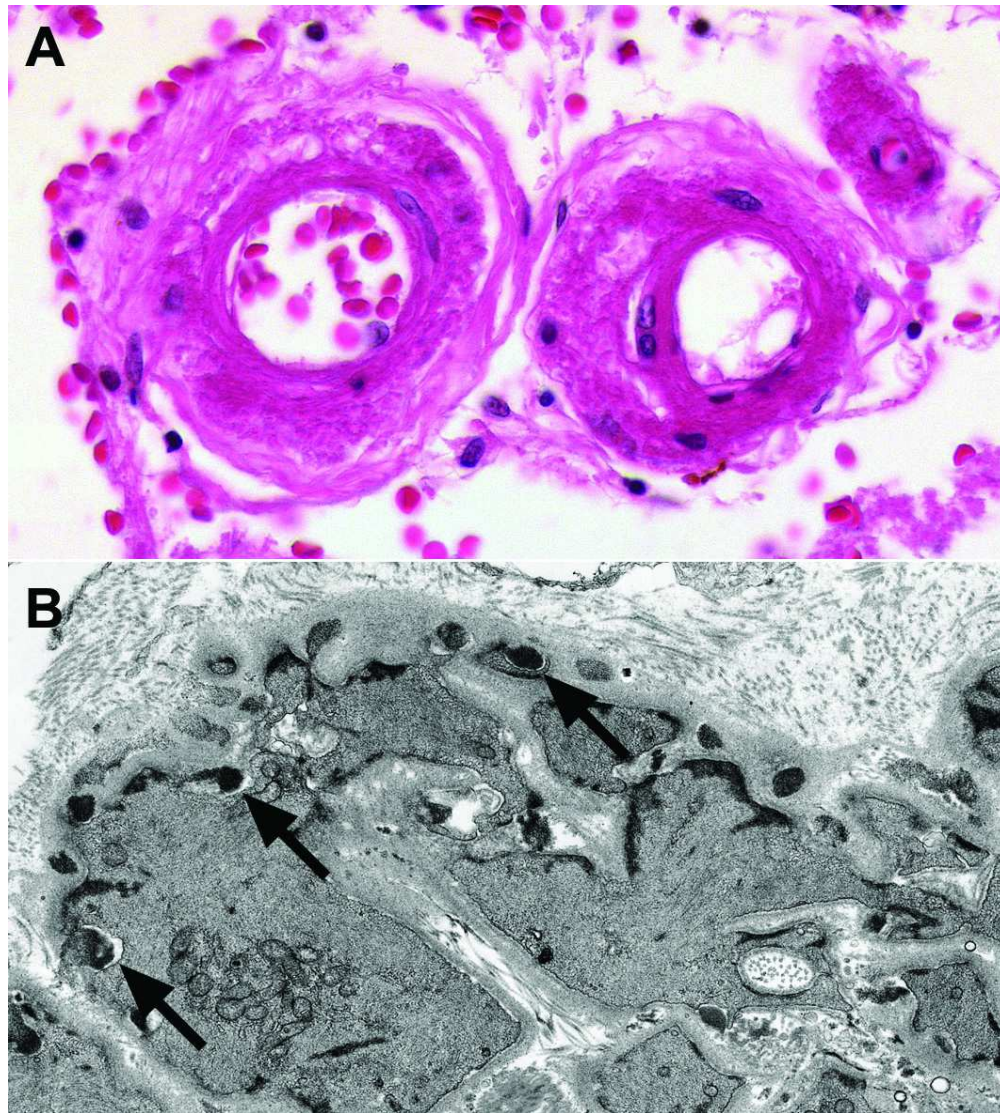


Fig 13. CADASIL. (A) The tunica media of these meningeal arterioles in CADASIL is replaced by granular eosinophilic material. (B) Electron microscopic examination of a dermal arteriole reveals accumulations of granular osmiophilic material ('GOMs') in caveolar indentations in the plasmalemma of vascular smooth muscle cells. The GOMs tend to be most prominent along the abluminal surface of the smooth muscle cells (arrows).
90x99mm (300 x 300 DPI)

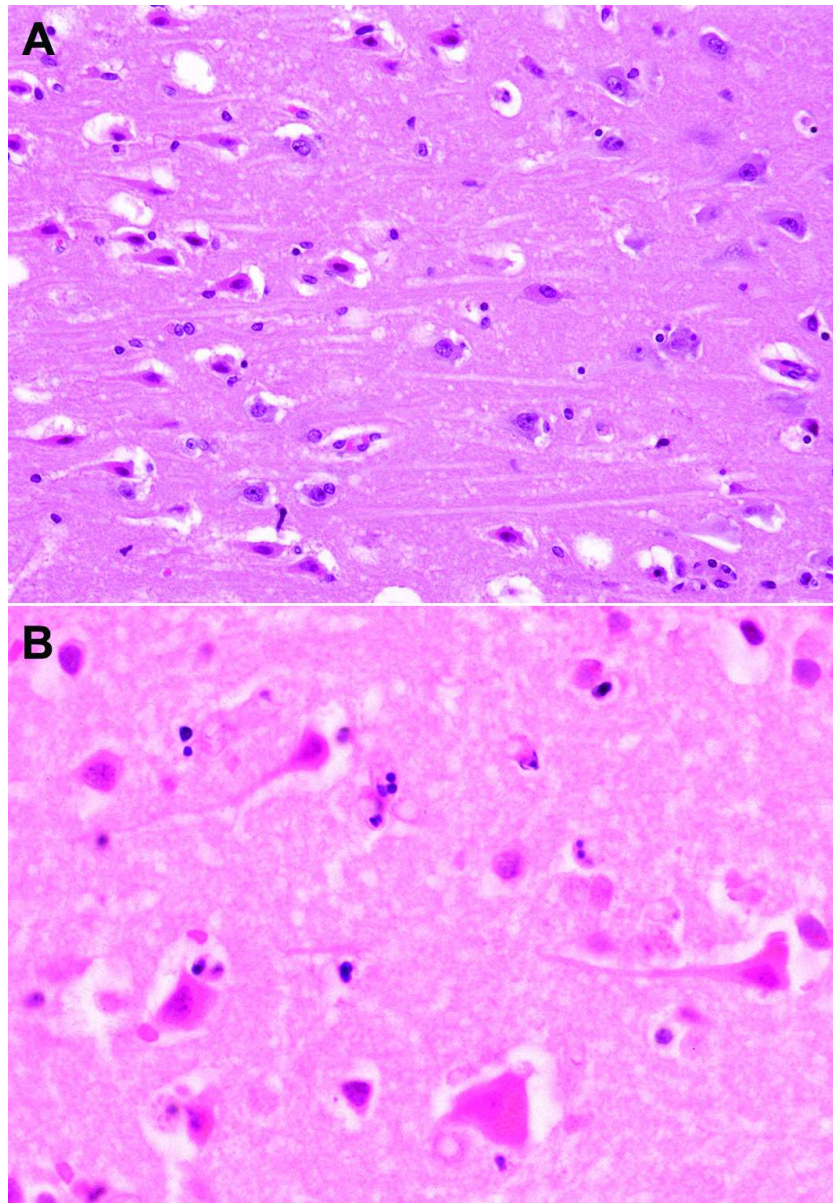


Fig 14. Histological changes in an acute infarct. (A) Compare infarcted cortex to the left of the panel with the preserved cortex to the right, at 4 to 5 hours. The infarcted neurons appear shrunken with pyknotic nuclei. Perineuronal glia have swollen, clear cytoplasm, and there is fine microvacuolation of the neuropil. (B) By 2 days most of the neuronal nuclei have become amphophilic or eosinophilic, making them increasingly difficult to distinguish from the surrounding cytoplasm. The section includes sparsely scattered apoptotic cells that are glial or inflammatory.
90x129mm (300 x 300 DPI)

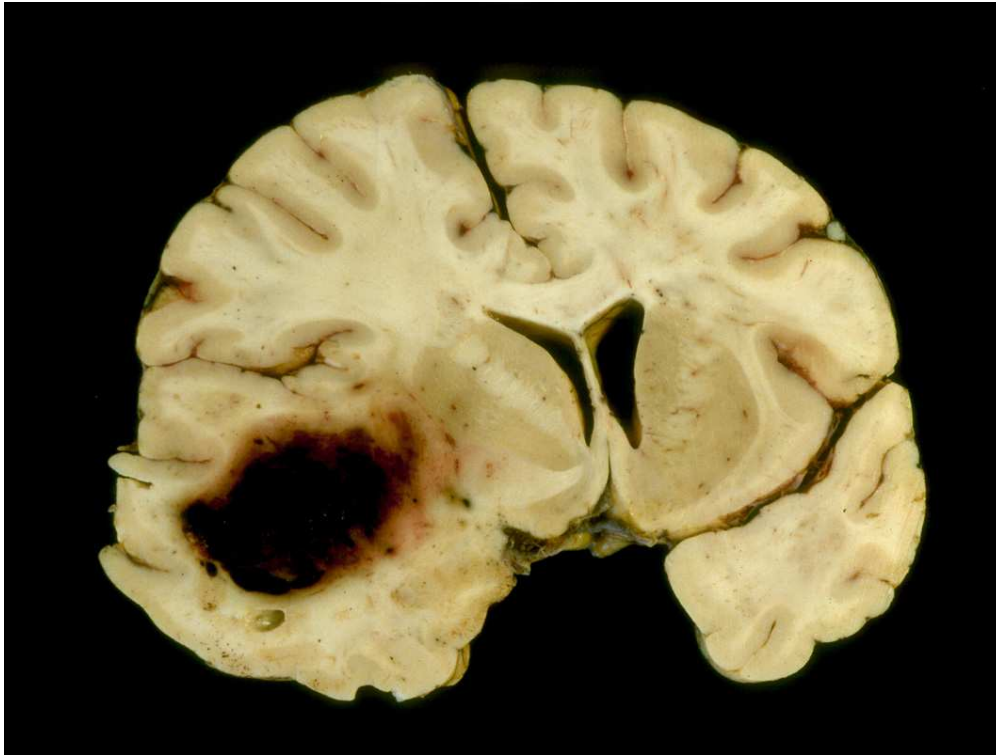


Fig 15. Haemorrhage into a tumour. A bleed was the presenting manifestation of this glioblastoma. Note the rather ill-defined margins of the haematoma and the poor definition of grey and white matter structures in the inferior part of the left temporal lobe.
90x67mm (300 x 300 DPI)

view

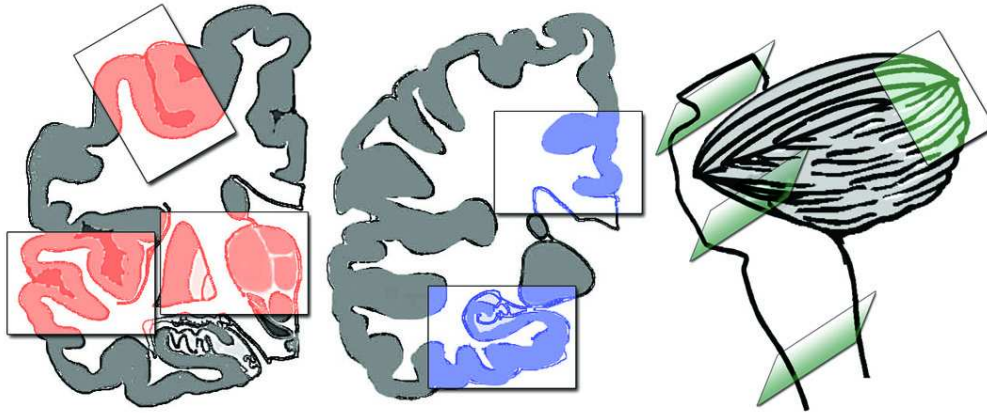


Fig 16. Sampling for histology. The orange, blue and green shaded areas indicate a typical set of blocks for assessment of ischaemic brain damage. Any regions of macroscopic abnormality should also be sampled.
90x40mm (300 x 300 DPI)

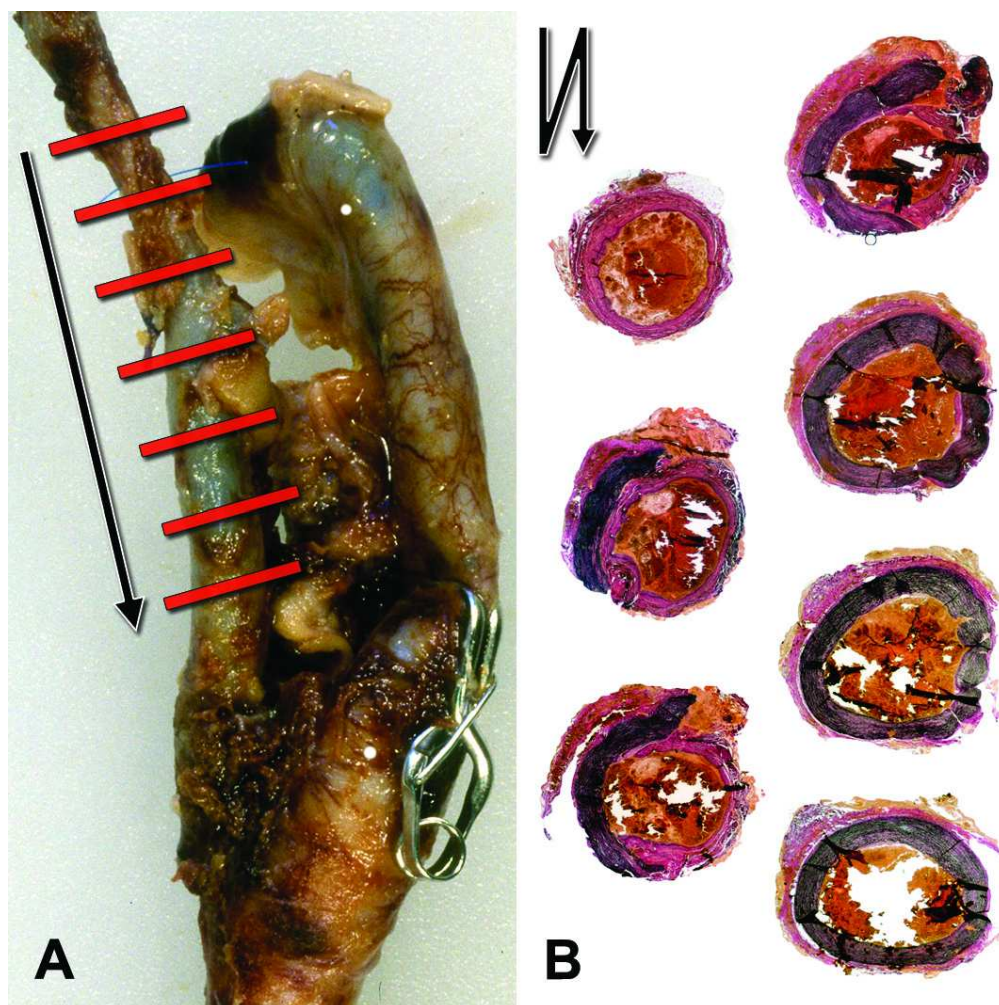


Fig 17. Serial block embedding. (A) Bifurcation of the right external carotid artery. A clip had been placed across the origin of the internal carotid artery, to cut off the blood flow to a large, inoperable aneurysm in the cavernous sinus, and an extracranial-intracranial bypass saphenous vein graft had been inserted between the external carotid artery and the right middle cerebral artery.

Unfortunately the graft thrombosed and the patient died. A particular concern of the surgeon was the integrity of the proximal arteriovenous anastomosis. A length of vessel across the anastomosis (arrow) was embedded intact in paraffin wax, removed from the wax bath and cut transversely at 3mm intervals (red bars). (B) The 3mm slices were placed face-down, in order (zigzag arrow), in a steel base mould, and embedded in a single paraffin block. This section shows a sequential series of levels through the anastomosis between the elastic-poor vein and the elastic rich artery. There is post-mortem blood clot in the lumen but the anastomosis is intact (elastin van Gieson).

90x90mm (300 x 300 DPI)

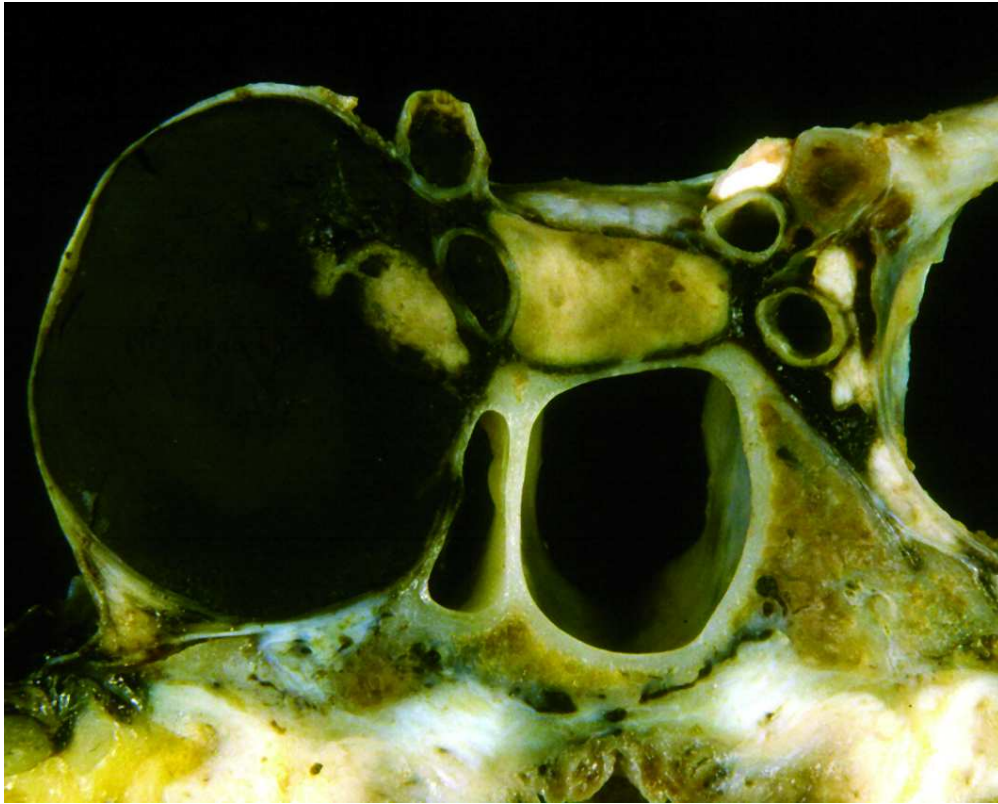


Fig 18. Giant aneurysm of the internal carotid artery within the cavernous sinus. This expanding aneurysm was compressing multiple cranial nerves and pushing into the pituitary fossa and decision was made to insert the extracranial-intracranial bypass graft described in the legend to Fig 17.
90x71mm (300 x 300 DPI)

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