



Module 3. The Blood Supply of the Brain Relating Vascular and Functional Anatomy

Objectives for Module 3

Knowledge

- Describe or sketch the course of the major arteries and their branches that comprise the carotid and vertebral-basilar systems.
- Name the major arteries or branches whose territories include the following structures:
 - Lateral parts of the hemisphere and large regions of internal capsule and basal ganglia (deep structures)
 - Anterior Medial and Superior parts of hemisphere including anterior corpus callosum
 - Posterior Medial and Inferior parts of the hemisphere including posterior corpus callosum
 - Thalamus
 - Medial brainstem
 - Lateral brainstem and Cerebellum
- Name the major arteries (and branches) that supply: Primary motor cortex for face, arm, leg; and corticobulbar and corticospinal fibers in deep white matter of hemisphere, and throughout the rest of their course in the forebrain and brainstem.
- Name the major arteries that supply the different components of the visual system, regions involved in language processing/production, spatial attention and visual-spatial orientation.
- List 4 important regions where collateral circulation may provide alternate routes for blood flow to the brain.

Clinical Applications and Reasoning

- Explain why collateral circulation may not protect against brain ischemia when a major artery is abruptly occluded.
- Explain why a slowly developing occlusion of the internal carotid artery in the neck might be totally asymptomatic.
- Name at least 3 structures where both intraparenchymal hemorrhages and small-vessel (lacunar) infarcts are common, and suggest an anatomic feature shared by their blood vessels.

It may be helpful to look at the relevant StrokeSTOP reference drawings as you read this module

The brain derives its arterial supply from the paired **carotid** and **vertebral** arteries. Every minute, about 600-700 ml of blood flows through the carotid arteries and their branches, while about 100-200 ml flows through the vertebral-basilar system.

The carotid and vertebral arteries begin extracranially, and course through the neck and base of the skull to reach the cranial cavity. The internal carotid arteries and their branches supply the anterior 2/3 of the cerebral hemispheres, including many deeper as well as superficial structures.

The vertebral arteries and basilar artery, with their branches, supply the remaining posterior and medial regions of the hemispheres, most of the diencephalon, the brainstem, cerebellum, and cervical spinal cord. The carotid and vertebral-basilar circulations are anatomically interconnected with each other, and with their counterparts in the opposite hemisphere, through the circle of Willis. However these connections may not be functionally significant if the connecting vessels are of small diameter or if pressure differences are too small to drive much blood flow.

The Carotid Circulation

Overview of Major Regions Supplied:

- optic nerves and retina
- cortex and deep white matter of the frontal and parietal lobes, and lateral aspects of the temporal and occipital lobes
- all of the corpus callosum except its posterior regions
- most of the basal ganglia and internal capsule.

Course of the Carotid Arteries and Formation of Major Branches

The right common carotid artery originates from the bifurcation of the brachiocephalic trunk, while the left common carotid artery originates directly from the aortic arch. Each common carotid then branches to form the internal and external carotid arteries. After the internal carotid artery ascends through the neck, traverses the temporal bone, and passes through the cavernous sinus it pierces the dura and finally reaches the subarachnoid space at the base of the brain.

Just after it enters the subarachnoid space the internal carotid artery usually gives rise to its first intracranial branch, the **ophthalmic artery**, which travels along the optic nerve into the orbit. There its branches supply the retina and other structures of the eyeball itself, as well as other structures in and around the orbit. The internal carotid artery continues in a superior direction and usually gives off two additional branches: the **posterior communicating** and **anterior choroidal** arteries.

The posterior communicating artery usually links the internal carotid to the posterior cerebral artery, and may be large or threadlike. However, in some individuals one or both of the posterior cerebral arteries retain their embryological state as direct branches of the internal carotid artery itself. The anterior choroidal artery is a small artery that supplies mainly deep structures. It usually branches from the internal carotid, but it may also branch from the middle cerebral artery. For this reason, we will discuss it with the middle cerebral artery. Finally, the internal carotid artery divides to form the **anterior and middle cerebral arteries**.

Anterior Cerebral Artery

The **anterior cerebral artery (ACA)** arises from the internal carotid at nearly a right angle. It sends deep penetrating branches (called lenticulostriate arteries) to supply the most anterior portions of the basal ganglia. It then sweeps forward into the interhemispheric fissure, and then runs up and over the genu of the corpus callosum before turning backwards along the corpus callosum. As it runs backwards it forms one branch that stays immediately adjacent to the corpus callosum while a second branch runs in the cingulate sulcus (just superior to the cingulate gyrus) To summarize, **ACA** supplies the medial and superior parts of the frontal lobe, and of the anterior parietal lobe.

ACA usually supplies these Key Functional Areas:

- septal area and anterior cingulate gyrus (limbic system -related cortex)
- anterior medial frontal lobe (complex roles in behavior and judgment)
- primary motor cortex for the leg and foot areas, and the medial frontal micturition center
- primary somatosensory cortex for the leg and foot
- most of the corpus callosum except its posterior part. Among other things, these callosal fibers enable the language-dominant hemisphere to find out what the other hemisphere is doing, and to direct its activities.

The short **anterior communicating artery** joins the two anterior cerebral arteries. It may provide collateral flow to the opposite hemisphere if the carotid artery is occluded on either side.

Middle Cerebral Artery

The **middle cerebral artery (MCA)** has a large diameter and branches at an acute angle from the internal carotid. The MCA passes laterally just underneath the frontal lobe, ultimately taking up a position between the temporal and frontal lobes in the lateral (Sylvian) fissure. The initial part of the MCA is a single vessel --its stem or M1 segment. As it passes laterally, the stem gives off a series of 6-12 long, small diameter, penetrating arteries that travel directly upward through brain tissue to supply large regions of the basal ganglia and internal capsule. These are the **MCA lenticulostriate arteries**.

Clinical Note: The lenticulostriate arteries are small diameter arteries that originate as right angle branches from the MCA stem (a large diameter vessel with a brisk, high pressure blood flow). These small penetrating arteries are particularly susceptible to damage caused by lipohyalinosis, pathologic changes weakening their walls that are associated with prolonged hypertension. They may either rupture, producing an intracerebral hemorrhage that is initially centered in the region they supply, or they may collapse, blocking the lumen and producing a small (lacunar) ischemic infarct in the tissue they normally supply. The lenticulostriate arteries are 'end arteries' and regions that they supply do not have significant collateral blood supply. Therefore their occlusion leads to stereotyped stroke syndromes.

Clinical Note: In the case of the lenticulostriate arteries, hemorrhage may remain localized to the putamen, caudate or internal capsule, affect other more distant white matter of the hemisphere, or even rupture into the ventricular system. Small-vessel (lacunar) infarcts may have serious functional consequences if they involve motor or sensory fibers in the internal capsule but may be 'silent' (produce no functional deficit) if they involve other small regions of white matter or the basal ganglia.

In addition to these lenticulostriate arteries, small penetrating **anterior choroidal artery** branches also supply deep structures including parts of the globus pallidus and putamen, and thalamus, as well as posterior regions of the internal capsule. Recall that the posterior limb of the internal capsule contains the corticospinal and corticobulbar motor tracts and connections between the somatosensory thalamus and cortex. Thus infarcts in either lenticulostriate or anterior choroidal territory can cause contralateral hemiparesis and hemianesthesia.

Once in the lateral fissure itself, the MCA stem divides into two or, in a smaller number of cases, three main cortical branches that supply almost the entire lateral surface of the brain as well as the insula.

Clinical Note: Large emboli carried up the carotid tend to be swept into the MCA stem, but may then get stuck at its narrower branch point within the lateral fissure, reducing blood flow to its major cortical branches. An embolus in the MCA stem could also block one or more small penetrating (lenticulostriate) arteries at their origin from the stem.

The **superior** (upper or suprasylvian) **cortical MCA branch** gives rise to several arteries that supply much of the lateral and inferior frontal lobe and often the anterior lateral parts of the parietal lobe. The **inferior** (lower or infrasyllvian) **cortical MCA branch** gives rise to arteries that supply the lateral temporal lobe including its anterior tip, variable amounts of the lateral parietal lobe, and much of the lateral occipital lobe. Note that details of the territories supplied by the superior and inferior cortical branches vary in different individuals.

Clinical Note: Emboli can lodge in one of these two major cortical branches, as well as in the smaller arteries that each of them will subsequently form.

Superior cortical branches of MCA usually supply these Key Functional Areas:

- Primary motor cortex for face and arm, and *axons* originating in the leg as well as face and arm areas that are traveling in the deep white matter toward the internal capsule as part of the corticobulbar or corticospinal tracts
- Broca's area and other related gray and white matter important for language expression -- in the language-dominant (usually L) hemisphere
- Frontal eye fields (important for 'looking at' eye movements to the opposite side)
- Primary somatosensory cortex for face and arm (But be aware that this cortex and even the primary motor cortex can be supplied by inferior branches in some people)
- Parts of lateral frontal and parietal lobes important for lateralized attention (perceptions of one's own body and of the outside world), visuospatial analysis, and for expressing emotions with the voice and body language -- in the R hemisphere

Inferior cortical branches of MCA usually supply these Key Functional Areas:

- Wernicke's and other related areas important for language comprehension in the language-dominant (usually L) hemisphere
- Parts of the lateral parietal and temporal lobe important for lateralized attention, and visuospatial analysis, and for the ability to interpret emotions in the voices and body language of others -- in the R hemisphere
- primary somatosensory cortex, and sometimes also part of the primary motor cortex
- Optic radiations. Axons that carry information about the contralateral superior quadrants of the visual fields loop forward into the temporal lobe (they are located anterior and lateral to the temporal horn of the lateral ventricle). Recall that the optic radiations traveling deep in the parietal lobe carry information from the contralateral inferior quadrants.

Clinical Note: There is a tendency for atheromatous plaques to form at branch points and curves of the cerebral arteries. Thus in the carotid circulation frequent sites of plaque formation include the extracranial internal carotid artery at its origin from the common carotid, in the stem (M1) MCA or its bifurcation into superior and inferior divisions, or in the ACA as it curves backwards over the corpus callosum.

Vertebral-Basilar Circulation

Overview of Major Regions Supplied

- upper cervical spinal cord
- brainstem and cerebellum
- most but not all of the thalamus and hypothalamus
- cortex and deep white matter of the posterior medial parietal lobes, and medial and inferior temporal and occipital lobes (including the posterior hippocampus)
- posterior part of the corpus callosum (splenium)

The **vertebral arteries** usually arise from the subclavian arteries. They ascend through the upper cervical transverse foramina, turn medially along the upper surface of the atlas, pierce the dura to enter the subarachnoid space and ascend into the cranial cavity via the foramen magnum. The vertebral arteries run alongside the medulla, giving rise to branches that participate in supplying the cervical spinal cord as well as the brainstem. They end by fusing to form the basilar artery.

Clinical Note: Cardiac emboli tend to enter the vertebral circulation far less frequently than the carotid circulation. Several facts of vascular anatomy may account for this. Each vertebral artery takes off from the subclavian at a sharp angle, and has a much smaller diameter. By contrast, the internal carotid artery is about the same diameter as the common carotid, and makes only a slight bend at its origin. Also, the vertebral-basilar system handles only about 20% of the total cerebral blood flow, while the carotid system handles far more.

The vertebral arteries help to supply the cervical spinal cord. The posterior spinal arteries and the two anterior spinal arteries, which fuse to form a single midline vessel, supply the upper cervical cord. Blood that supplies more caudal regions of the spinal cord flows to it via radicular arteries that are branches of the thoracic and abdominal aorta. There is a great deal of variability in this pattern. The artery of Adamkiewicz is one of the most important radicular arteries, and in some individuals it may provide the entire arterial supply for the lower two-thirds of the cord.

The vertebral and basilar arteries supply the brainstem and cerebellum. Perhaps the most important thing to recognize about the brainstem's blood supply is just how variable the arteries can be in size and position, but still provide adequate perfusion. This means that clinical syndromes produced by occlusion of a particular artery are also variable. Patients you will encounter may present with fragments or combinations of "classic" brainstem syndromes.

Brainstem arteries in the medulla, pons and midbrain have similar patterns of distribution:

- **Medial parts of the brainstem** as far dorsal as the ventricle are supplied by long, slender **paramedian penetrating arteries**

Clinical Note: Like the lenticulostriate branches of MCA, these paramedian arteries are at risk for hypertensive damage, particularly in the pons. Large hemorrhages in the ventral medial pons classically damage the corticospinal (and corticobulbar) tracts and other medial structures bilaterally. Occlusion of these paramedian vessels in the pons can produce small (lacunar) infarcts that may infarct these same structures.

- **Dorsolateral parts of the brainstem** are supplied by **short circumferential penetrating branches of the vertebral or basilar arteries**, or by branches of one of the major 'cerebellar' arteries as they curve around the brainstem to reach the cerebellum (**penetrators from long circumferential arteries** (primarily AICA or PICA). The midbrain is also partially supplied by posterior cerebral artery branches.

The blood supply of the medulla is derived from the two vertebral arteries. The midline **anterior spinal artery**, formed from the fusion of medial branches from each vertebral, supplies part of the central medulla (as well as much of the upper cervical cord). From its lateral side each vertebral gives off a variable branch the **posterior inferior cerebellar artery (PICA)**. PICA has a complicated looping course as it swings out around the inferior olives, and runs along the dorsal lateral surface of the medulla before turning laterally and supplying the inferior surface of the cerebellum. The vertebral arteries fuse at the junction between the medulla and the pons to form the single midline **basilar artery**, which then proceeds rostral along the surface of the anterior pons. The basilar artery also gives rise to additional large lateral arteries, most importantly, the **anterior inferior cerebellar arteries (AICA)** and the **superior cerebellar arteries**.

The three pairs of named cerebellar arteries supply the posterior inferior, anterior inferior, and superior surfaces of the cerebellum respectively. The superior cerebellar artery also sends small branches penetrating deeply into the internal (deep) nuclei of the cerebellum.

Clinical Note: Less commonly, these penetrating superior cerebellar artery branches are also at risk for hypertensive hemorrhage, with bleeding often occurring deep within the cerebellum. Such a cerebellar hemorrhage can produce deficits related to the cerebellum such as postural instability or limb ataxia. It may also affect the brainstem by compression or by rupture into the fourth ventricle. This can kill the patient by interrupting vital respiratory and cardiac functions

Vertebral-basilar branches supply the following key functional areas:

Brainstem Region	Medial Structures	Dorsolateral Structures
Rostral Midbrain	*CST and CBT in cerebral peduncle Superior cerebellar peduncle Oculomotor nucleus / CNIII axons Medial longitudinal fasciculus Rostral Reticular formation	
Mid-Pons	Medial longitudinal fasciculus Reticular formation CST and CBT Griseum pontis	Middle cerebellar peduncle Trigeminal sensory and motor nuclei / axons Spinothalamic tract
Caudal Pons	Abducens nucleus/CNVI axons Motor fibers of CNVII PPRF (lateral gaze center) CST and CBT Medial lemniscus Caudal Reticular formation	Facial motor nucleus/CNVII axons Middle cerebellar peduncle Descending tract/nucleus of V Spinothalamic tract Vestibular and Cochlear nuclei CN VIII axons
Rostral medulla	Hypoglossal nucleus/CNXII axons CST Medial lemniscus Caudal Reticular formation	Nucleus ambiguus/CNIX and CNX axons Descending tract/nucleus of V Spinothalamic tract Vestibular nuclei Inferior cerebellar peduncle

*CST = corticospinal tract; CBT = corticobulbar tract

Clinical Note: If an embolus travels in one vertebral artery, its passage may be blocked where the vertebral arteries join to form the basilar artery. More often, however, it keeps going, traversing the basilar artery (which has a large diameter) but is arrested at the upper bifurcation of the basilar into the posterior cerebral arteries or in one posterior cerebral artery (PCA)..

As each PCA passes around the cerebral peduncles, it forms short penetrating branches to the **midbrain**, and gives rise to a series of long, slender penetrating arteries that supply much of the **hypothalamus and thalamus**. The circle of Willis partially surrounds the hypothalamus, and additional small perforators from its other arteries also help to supply the hypothalamus.

Clinical Note: After the basal ganglia and internal capsule, the thalamus is the next most frequent site of hypertensive intracerebral hemorrhage and small-vessel infarcts. Thalamic hemorrhages may be confined to the thalamus, or the bleeding may involve the neighboring internal capsule, subthalamic nucleus and midbrain, and even rupture into the third ventricle.

The **cortical branches of PCA** supply the posterior medial parietal lobe and the splenium of the corpus callosum, inferior and medial part of the temporal lobe including the hippocampus and entorhinal cortex (medial temporal lobe), and the medial and inferior surfaces of the occipital lobe.

Penetrating branches of PCA usually supply these Key Functional Areas:

DIENCEPHALON including the thalamus, subthalamic nucleus, and hypothalamus

MIDBRAIN including the cerebral peduncle, third nerve and nucleus, superior cerebellar peduncle, and reticular formation

Note: The upper parts of the Basilar artery also help supply the midbrain

Cortical branches of PCA usually supply these Key Functional Areas

PARIETAL AND OCCIPITAL LOBE (Posterior branches)

- Optic radiations and striate cortex (the primary visual cortex may be entirely supplied by PCA, or the tip of the occipital lobe where the fovea is mapped may be located in the border zone shared by PCA and MCA)
- Splenium of the corpus callosum (these crossing fibers participate in the transfer of visual information to the language-dominant hemisphere)

MEDIAL TEMPORAL LOBE (Anterior branches)

- Posterior hippocampus, entorhinal cortex and the fornix (these structures are critical for laying down new declarative memories)

Clinical Note: Recall that atherosclerotic plaque forms at branch points or curves in vessels. In the vertebral-basilar circulation, it is most frequent in the cervical part of the vertebral arteries and where the vertebral arteries join to form the basilar artery. Plaques are also common in the PCA as it swings around the midbrain on its way to medial parts of the parietal, occipital, and temporal lobes.

Overall cerebral blood flow is constant, but can vary locally

Although we've discussed anatomic variations of the cerebral arteries, our description up to now suggests that they are a system of rigid branching pipes. In reality, however, the cerebral vessels continuously adjust their own caliber by contraction and relaxation of smooth muscle in their walls so that:

- constant cerebral blood flow is normally maintained over mean arterial pressures ranging between approximately 60-150 mm Hg. Thus as intra-arterial pressure goes up, cerebral vessels normally constrict and conversely when pressure drops, the cerebral vessels dilate. However, at extremely low or high arterial pressure levels this response fails, and in those situations cerebral blood flow follows blood pressure more directly. The concept that cerebral vessels themselves have a role in controlling cerebral blood flow is often referred to as **autoregulation**.
- local blood flow can change in response to local neuronal metabolism. For example, increases in arterial (and hence extracellular) carbon dioxide tension in a specific brain region will lead to dilation of its arterioles and an immediate increase in local blood flow.

These responses protect the brain from ischemia by increasing cerebral blood flow (delivery of oxygen and glucose, and removal of carbon dioxide and other metabolites) in the face of decreased arterial pressures. They also support regional variations in brain activity by providing rapid local adjustments of blood flow.

Collateral circulation may modify the effects of cerebral ischemia

There is usually not enough redundancy in the blood vessels of the brain to support function if one artery is suddenly occluded. If there were, ischemic strokes would be far less frequent.

Many smaller penetrating brain arteries such as the lenticulostriate branches of MCA that supply the basal ganglia and internal capsule, as well as the penetrating branches from arteries on the brain surface that supply deep white matter, are **terminal arteries**. This means that they form few if any connections with other arteries. When they are occluded, the brain regions they supply will therefore become ischemic.

Other arteries form anastomoses that potentially could protect the brain from infarction, or at least limit the amount of damage, by providing alternative routes for blood flow.

Common and Important Anastomoses can occur between:

- External carotid and internal carotid via branches of the ophthalmic artery
- The major intracranial arteries via the circle of Willis (for example one carotid might supply parts of the contralateral hemisphere by connections through the anterior cerebral and anterior communicating arteries)
- Muscular branches of cervical arteries and the extracranial vertebral or external carotid arteries
- Small cortical branches of ACA, MCA, and PCA, or branches of the major cerebellar arteries

How effective the collateral circulation can be in supporting blood flow and hence neurologic function depends on the size of the arteries. The smaller the diameter of the collaterals, the less likely it is that they will be able to carry enough blood to prevent infarction.

The speed at which the occlusion of an artery occurs therefore can play a role in determining whether collateral circulation will be sufficient to prevent infarction.

If a major artery is gradually occluded by atherosclerosis, there may be time for preexisting collateral channels to enlarge to the point where they can support major blood flow. This may happen, for instance, when there is gradual occlusion of the internal carotid artery in the neck by the build up of atherosclerotic plaque. In this situation retrograde flow may develop *from* the external carotid through the ophthalmic artery *to* the intracranial internal carotid, bypassing the blockage. Some people with one or both internal carotid arteries largely or entirely occluded show no neurologic deficits thanks to collateral circulation around the orbit.

The ‘circle’ of Willis can be a source of effective collateral circulation. At first glance, the anatomy of the circle of Willis suggests that blood can be easily shunted from one side of the brain to the other, or from the carotid to the vertebral-basilar system or vice versa. This may indeed occur, especially in younger individuals. However if one or more of the arteries that forms the circle is narrowed, then the circular connections might not allow enough blood flow to compensate for most *abrupt* arterial blockages. In this case, it would provide little ‘protection’ against sudden blockage of a vessel by, for example, a cardiac embolus. In the same patient, the circle might be able to compensate for slowly developing arterial occlusions produced by build-up of atherosclerotic plaque, since even if arteries of the circle are initially small diameter they may expand over time in response to increasing hemodynamic demands.

Before we leave the circle of Willis, we should point out that places where large arteries branch or bifurcate are favorite locations for the formation of **saccular (‘berry’) aneurysms**. In these locations the muscular part of the arterial wall is relatively weak, and balloon-like swellings that are prone to rupture may occur. The greatest number of aneurysms involve the anterior portion of the circle of Willis: the junction of the anterior communicating artery with ACA, the junction of the internal carotid and posterior communicating artery, or the division of MCA into superior and inferior branches within the lateral (Sylvian) fissure. If an aneurysm ruptures, blood under high pressure is forced into the subarachnoid space, which contains the circle of Willis, and possibly into the interior of neighboring brain substance as well. Such non-traumatic subarachnoid hemorrhages account for about 3% of all strokes.

Concept of Border zone versus core territory of the cerebral vessels

We have seen that the cerebral cortex is supplied by the cortical branches of MCA, ACA, and PCA. These arteries reach the cortical surface, divide, and give off branches that penetrate the cortex perpendicularly. Long arteries and arterioles pass through the gray matter and penetrate the white matter to a depth of 3-4 cm, where they supply the core of the hemisphere’s white matter. These arteries intercommunicate very little, and thus constitute many independent small systems. The deeply penetrating vessels that branch directly from major arterial stems (like the lenticulostriate branches of MCA) also do not interconnect. Therefore if one of these arteries is occluded, the “downstream” tissue it normally supplies will be infarcted since it has no other source of blood flow.

By contrast, the short surface arteries supplying the cortical gray matter do anastomose. The anastomoses form a continuous network of tiny arteries covering the perimeters or **border zones** between the core (central) territories of the 3 major cerebral arteries. Since these anastomoses are usually tiny, they carry little blood. Therefore, if one of the major arteries is occluded, the anastomoses cannot rescue the core territory of that artery from infarction. However, they may be able to supply the border zone, so that the size of the infarction is reduced somewhat. Additional contributions of leptomeningeal collaterals connecting the ACA, MCA and PCA along surface of the brain may also serve to limit ischemia. Conversely, if there is a dramatic impairment of systemic blood pressure (perhaps secondary to cardiac arrest or massive bleeding), or decreased pressure specifically in the carotid system (due to an occlusive event), the border zones, which are the regions of each vascular territory farthest from the core will become ischemic first.

ACA – MCA Border Zone may include these Key Functional Areas:

- Hip, shoulder or less usually arm region of primary motor or somatosensory cortex
- Areas related to language production – in the dominant hemisphere
- Frontal eye fields
- Frontal lobe motor planning areas

ACA/MCA – PCA Border Zone may include these Key Functional Areas:

- Visual radiations
- Foveal region of the striate cortex in some people (in others it may be in PCA territory)
- Inferior temporal lobe cortex (the fusiform gyrus) important for visual recognition
- Areas related to language comprehension, word finding, and possibly reading –in the dominant (usually left) hemisphere
- Areas of parietal lobe important for lateralized attention and visuospatial perceptions – in the right hemisphere

Infarction or hemorrhage caused by problems in the venous rather than the arterial system is fairly rare. Venous thrombosis is associated with medical conditions that lead to a prothrombotic state, and also with blood volume depletion, medications, or head trauma. Its frequency increases in women during pregnancy particularly in the third trimester, and in the first 6 weeks postpartum. Usually large sinuses (e.g. the superior sagittal sinus) and large veins are most affected. Said simply, what often happens is that blockage of a large vein can ‘back up’ the circulation in a region, causing decreased arterial flow that in turn produces ischemia and infarction (and sometimes hemorrhage into the infarcted tissue).

Clinical findings in these patients usually do not reflect the typical arterial territory syndromes that you have been learning about. One of the reasons for this may be that there are far more functional anastomoses in the venous than in the arterial system. While problems secondary to occlusion of cerebral veins may not be particularly helpful in learning about the territories supplied by the cerebral arteries, they are very important to consider from a clinical perspective. They are rare, accounting for only about 1% of all strokes, but they are treatable if identified early on.