A 39-year-old, right-handed man was admitted to our hospital because of sudden onset of right hemiparesis and aphasia. His medical history included atopic dermatitis, and included no episodes of trauma. He was alert on admission; however, his speech and comprehension were impaired, and was assessed a National Institutes of Health Stroke Scale score of 15. Brain computed tomography showed obscuration of the lentiform nucleus on the left side. Computed tomography angiography (CTA) demonstrated an occlusion of the left MCA at the horizontal segment. Laboratory examination yielded unremarkable results. Administration of intravenous recombinant tissue plasminogen activator (IV rt-PA) was started at 164 min after symptom onset (alteplase, 0.6 mg/kg). However, no neurological improvement was observed. Transcranial color-coded flow velocity measurements demonstrated reperfusion of the left MCA just after IV rt-PA administration, and 1.5T MRI detected an acute infarction in the left putamen, insular cortex, and corona radiata (fig. 1a). Magnetic resonance angiography results could not be evaluated because of motion artifacts. On day 4, CTA showed dilatation of the left MCA (fig. 1b) and the double lumen sign (fig. 1c), on the basis of which spontaneous MCAD was strongly suggested. However, atherothrombic occlusion, while unlikely given the circumstances, could not be completely ruled out at the time, since the fat-saturated T1-weighted imaging needed to make an unambiguous diagnosis of MCAD was not performed. On day 17, fast spoiled gradient-echo images...
acquired on a General Electric (Waukesha, Wisc., USA) Signa 3.0T system demonstrated that the narrowed true lumen was located in front of a dilated pseudolumen, which was indistinguishable by CTA (fig. 1d, e). Neurological symptoms gradually improved, although mild hemiparesis and aphasia remained. On day 24, the patient was transferred to a different facility to continue rehabilitation.

Discussion
We consider this report notable for the following reasons: first, compared to clinical routine magnetic resonance angiography that sometimes misses MCAD, high-resolution 3D morphological MRI, such as spoiled gradient echo, can visualize fine arterial wall structures. With high-field 3T MRI, noninvasive high-resolution volume images can be obtained within a suitable time frame to inform the initial diagnosis [5, 6]. We recommend utilizing high-resolution 3D morphological MRI for suspected MCAD cases. Second, recent reports have suggested that the safety and outcome of IV rt-PA is not affected by the relationship between the dissection and stroke [7, 8]. Doijiri et al. [9] reported an MCAD case similar to that described herein, which was uneventfully treated with rt-PA. Although the possibility of subarachnoid hemorrhage must also be considered [10], it might be safe to perform IV rt-PA.

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We report no disclosure associated with this report.

References