



Abdominal aortic aneurysm: Common problem, atypical presentation

Case Description

Abdominal Aortic Aneurysms (AAA) frequently develops without causing any symptoms, until they rupture. From that moment on, its prognosis is usually gruesome [1].

Caucasian male, 75-years-old, with history of heart failure with severely depressed left ventricle ejection fraction in the setting of dilated cardiomyopathy, hypercholesterolemia and heavy smoking (180 pack-year). Admitted to the emergency department with complaints of fever, dysuria, trembling and 3 episodes of gastric

vomit in the previous four hours. On clinical examination he presented with fever (38.5°C), elevated blood pressure (151/83 mmHg) and a pulsatile abdominal mass, located in the central quadrants, with approximately 10 cm of transversal diameter. A thoracic-abdominal-pelvic Computerized Tomography (CT) angiography showed an infra renal abdominal aortic aneurysm with 12 cm of transversal diameter with signs of active intramural hemorrhage and high risk of rupture. All the remaining branches of abdominal aorta were permeable. An Endovascular Repair of the Aneurysm (EVAR)

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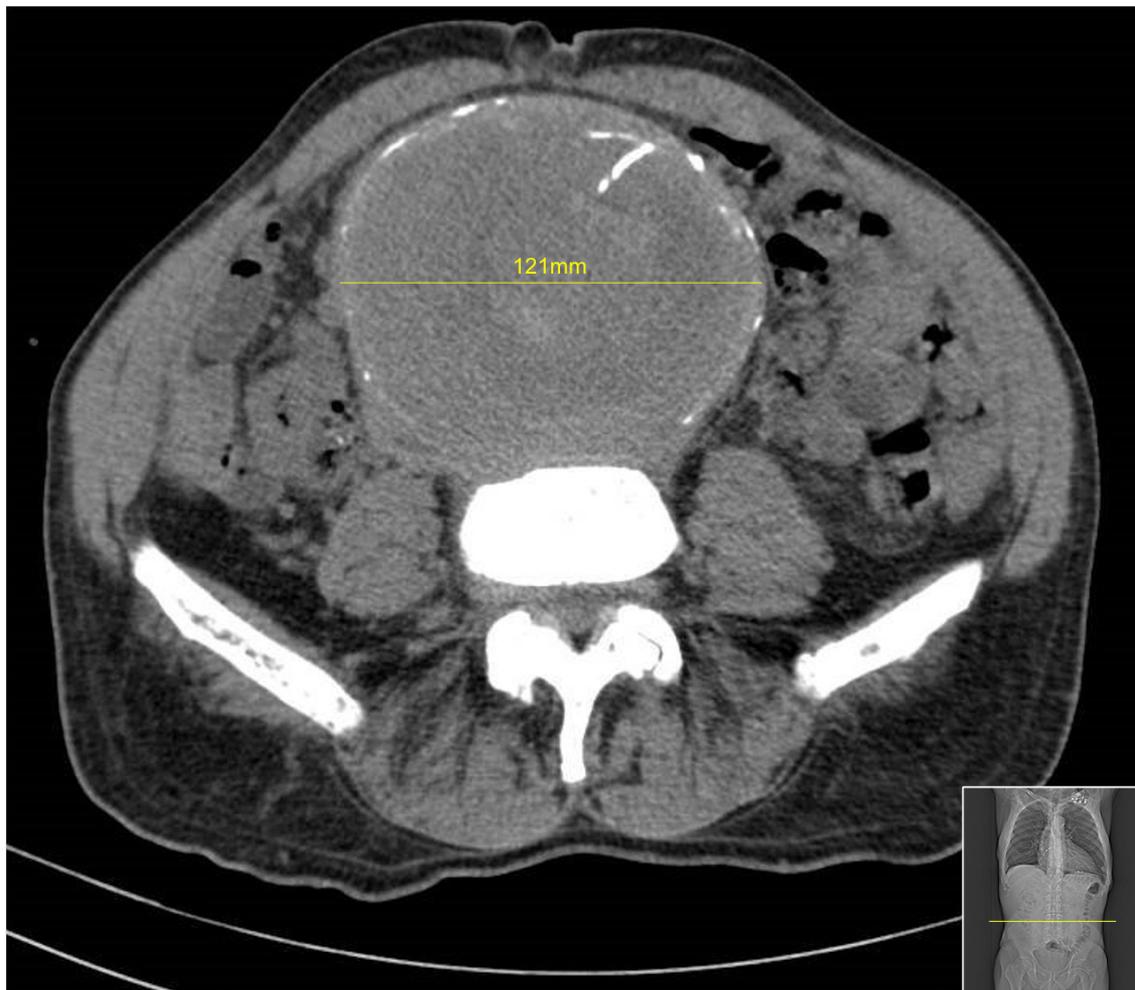


FIGURE 1. Computed tomography: Abdominal aortic aneurysm with 121 mm of maximum diameter. Irregular lumen with mural thrombus without clear differentiation between the wall of the aorta and the thrombus.

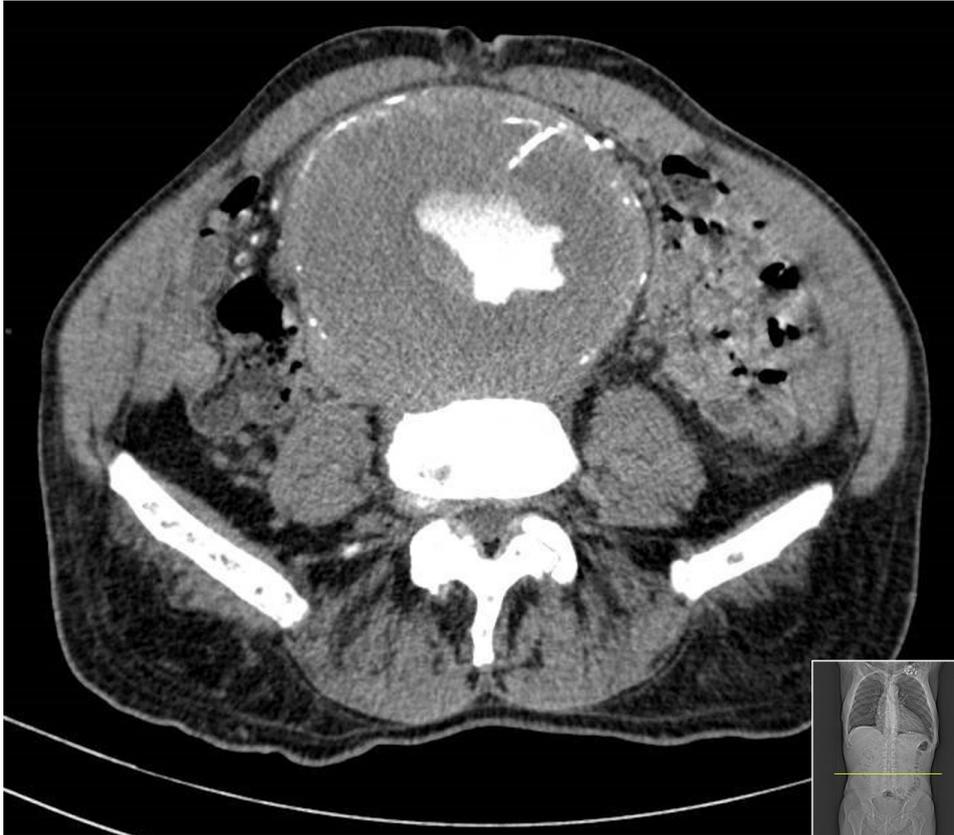


FIGURE 2. Computed tomography with angiography: the irregular lumen is visible, and also calcified plaque suggestive of wall rupture, although not transparietal.

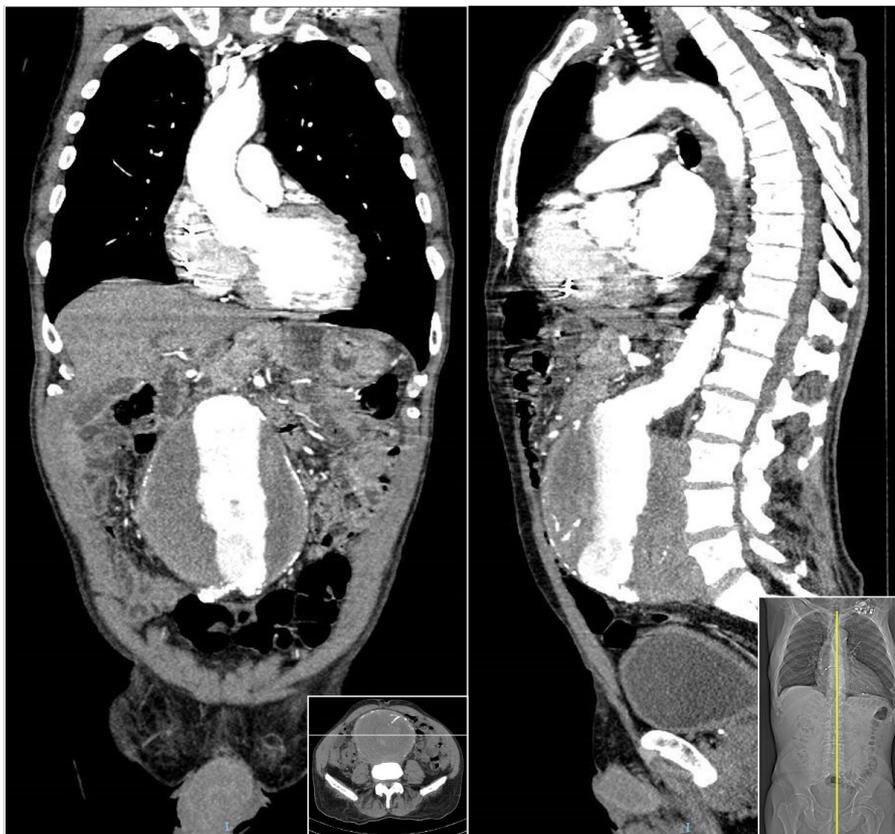


FIGURE 3. Computed tomography with angiography: abdominal aortic aneurysm extending from the infrarenal portion of the aorta to the bifurcation of the iliac arteries.

was performed, without any intra-operative complications. Nevertheless, 24 hours later he presented with acute abdominal pain and a new abdominal-pelvic CT angiography showed an acute occlusion of the Superior Mesenteric Artery (SMA). He was taken to the operating room but there was no possibility of reversing the extensive intestinal necrosis and he died 24 hours later. The clinical relevance of this case is mainly based on its atypical presentation. Also,

early detection of AAA allows elective repair and improves outcomes, so this too demonstrates the importance of screening for this entity in all men at 65 years of age, in accordance with the most recent guidelines published by the European Society for Vascular Surgery [2]. In addition, the cause of death in this patient was a thromboembolic occlusion of the SMA, a rare post-operative complication in the EVAR era [3].

References

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