

acute onset and pulselessness of bilateral femoral artery in the emergency services.

CVP-7

AORTIC ARCH PSEUDOANEURYSM ON PENETRATING ULCER: DELAYED CLOSURE AFTER ENDOVASCULAR TREATMENT

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Objective: We share our experience with the endovascular approach to pseudoaneurysm of the aortic arch in a patient with high-risk for aortic arch replacement under extracorporeal circulation.

Methods: A 65-year-old patient with history of hypertension, chronic obstructive pulmonary disease, non-insulin dependent diabetes, obesity, and hyperlipidemia was referred to our hospital for evaluation of thoracic pain and dysphonia. A chest computerized tomography (CT)-scan showed a penetrating ulcer 1.2 cm distal to the origin of the left common carotid artery and immediately proximal to the left subclavian artery. A large pseudoaneurysmal sac measuring 63 mm×67 mm, was located on the anterior left side of the aortic arch towards the wall chest (image 1). The patient's EuroSCORE was 13, and predictive mortality was 41.12%. An endoprosthesis was introduced under fluoroscopy control and controlled hypotension (80 mmHg) in total anesthesia, through a left femoral artery approach. We choose an endoprosthesis medtronic valiant with a diameter of 26 mm and a length of 100 mm, with an oversizing of 20%. The endoprosthesis was deployed in such a way that the freeflo was on the origin of the left common carotid artery (image 2). Fluoroscopy was performed to confirm appropriate graft deployment and the presence of small type one endoleak partially refilling the pseudoaneurysm. Patient's pain resolved soon after placement of the stent graft. A CT-scan, performed seven days later, confirmed the presence of a small endoleak with slow pseudoaneurysm refilling (image 3).

Results: The postoperative period was event free, and the patient was discharged on day 8. A follow-up at twenty days after the procedure, suggested progressive thrombosis of the pseudoaneurysm sac (image 4) and, at three months, demonstrated occlusion of the pseudoaneurysm with complete resolution of the endoleak (image 5-6). The patient is actually alive and completely asymptomatic.

Conclusions: The endovascular treatment should be considered as a potential alternative to conventional aortic arch aneurysm surgery in high-risk patients. Our case shows that an optimal result can be obtained in selected cases through a progressive obliteration of the pseudoaneurysm sac, secondary to the hemodynamic changes triggered by the endovascular prosthesis.

combined thoracic pain and massive hematemesis. He had undergone prior emergency surgical repair endografting of his descending aorta for a traumatic transection three years before, and a computed tomographic scan of the chest documented a large aortic arch pseudoaneurysm that surrounded the high-esophagus.

Results: The first patient was treated by an intraluminal esophageal stenting and an endovascular repair of thoracic aorta. The second received a mediastinal debridement and placement of a new endograft into the aortic arch. Both of them died of sepsis and multiple organ failure at 6 and 43 postoperative days.

Conclusions: Aortic repair and esophageal reconstruction are essential principles in the management of AEF after endovascular stent-grafting of the aortic aorta. Endovascular repair provides an alternative therapeutic option to control bleeding and allow for continued intervention in a stabilized setting. Patients with AEF after stent-graft repair of the thoracic aorta should undergo drainage, esophageal repair or diversion to minimize the risk of ongoing infectious complications. We believe that due to the infectious nature of AEFs endovascular treatment should only be considered as a bridging method. Definitive surgical elimination of the infectious focus has to be carried out after initial stabilization. Exclusive endovascular treatment should be reserved for palliative care of patients that are no candidates for open surgery.