

Surgical images: soft tissue

Recurrent aneurysms

Five years after surgical repair of an infrarenal aortic aneurysm, a 64-year-old man presented with pulsatile abdominal masses located in both lower abdominal quadrants. He had a history of myocardial infarction in 1974, coronary artery bypass surgery 8 years later and a second bypass procedure for recurrent angina in 1994. The infrarenal aortic aneurysm was repaired with a straight graft (Fig. 1, panel A), excluding the iliac bifurcation. The patient still had Canadian Cardiovascular Society class II angina and reversible inferior ischemia on thallium-Persantine scanning. Nuclear magnetic imaging (NMI) showed an 8-cm left common iliac and a 4-cm right common iliac aneurysm (Fig. 1, panel A). Owing to his medical condition and his previous surgical procedures, we elected first to occlude the left internal iliac artery with endovascular coils. Two weeks later, a custom-made stent-graft (Talent; Medtronic Inc., Minneapolis, Minn.) was installed from the former infrarenal graft to the left external iliac artery. Then a femorofemoral bypass was performed with use of an 8-mm diameter Dacron graft. Through a

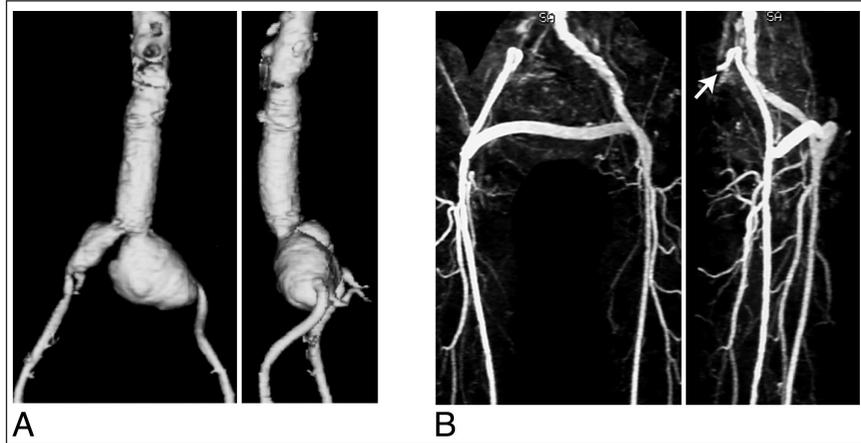


FIG 1. Panel A shows the repair of the infrarenal aortic aneurysm with a straight graft and left and right common iliac artery aneurysms. Panel B shows the femoro-femoral bypass and occlusion of both aneurysms with preservation of the left internal iliac artery.

limited suprainguinal retroperitoneal approach, the right common iliac artery was divided just above the take-off of the internal iliac artery. Postoperative NMI (Fig. 1, panel B) revealed that both aneurysms were excluded, with preservation of the left inferior internal artery (ar-

row in panel B) to maintain pelvic vascular status. Two years later, the patient was asymptomatic. Routine CT showed partial involution of the left iliac aneurysm and no periprosthetic leak.

Competing interests: None declared.

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