



Infected Viabahn Stent Graft in the Superficial Femoral Artery[☆]

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Abstract We present a case of an infected stent graft in the superficial femoral artery (SFA). A 67-year-old woman underwent excision of an infected Viabahn stent graft. At exploration there was no apparent artery around the majority of the stent graft, suggesting that the SFA had been autolysed.

Infected stents and stent grafts are rare in the SFA position. The risk of infection is likely minimised with standard treatments including drainage of infection prior to stent graft placement and periprocedural antibiotic administration. Successful management will, in most cases, require excision of the stent graft and adjunctive arterial reconstruction, as necessary. © 2011 European Society for Vascular Surgery. Published by Elsevier Ltd. All rights reserved.

Infections are unusual in peripheral arteries treated with endovascular techniques. The use of stents and stent grafts for segment superficial femoral artery (SFA) disease might be associated with a higher infection rate, but there are few published descriptions of such problems. We present a case of an infected stent graft in the SFA.

Case Report

A 67-year-old diabetic woman presented with a 2.5-month history of foot pain and two ischaemic foot ulcers, one measuring 2.2 × 2.4 cm over the lateral aspect of the 5th metatarsophalangeal joint, the other measuring 1.1 × 2.0 cm over the posterior heel. There was no fever, local erythema, drainage, odour or other suggestion of infection. The patient underwent endovascular treatment for atherosclerotic disease including placement of a 6 mm × 15 cm Viabahn stent graft (W.L. Gore, Flagstaff, AZ, USA) in the distal SFA and atherectomy of the popliteal artery and anterior tibial artery (Silverhawk, Fox Hollow/ev3, Plymouth, MN, USA) on hospital day 4 using contralateral femoral access (Fig. 1). The lesions were initially crossed with hydrophilic wires and no 'crossing device' was

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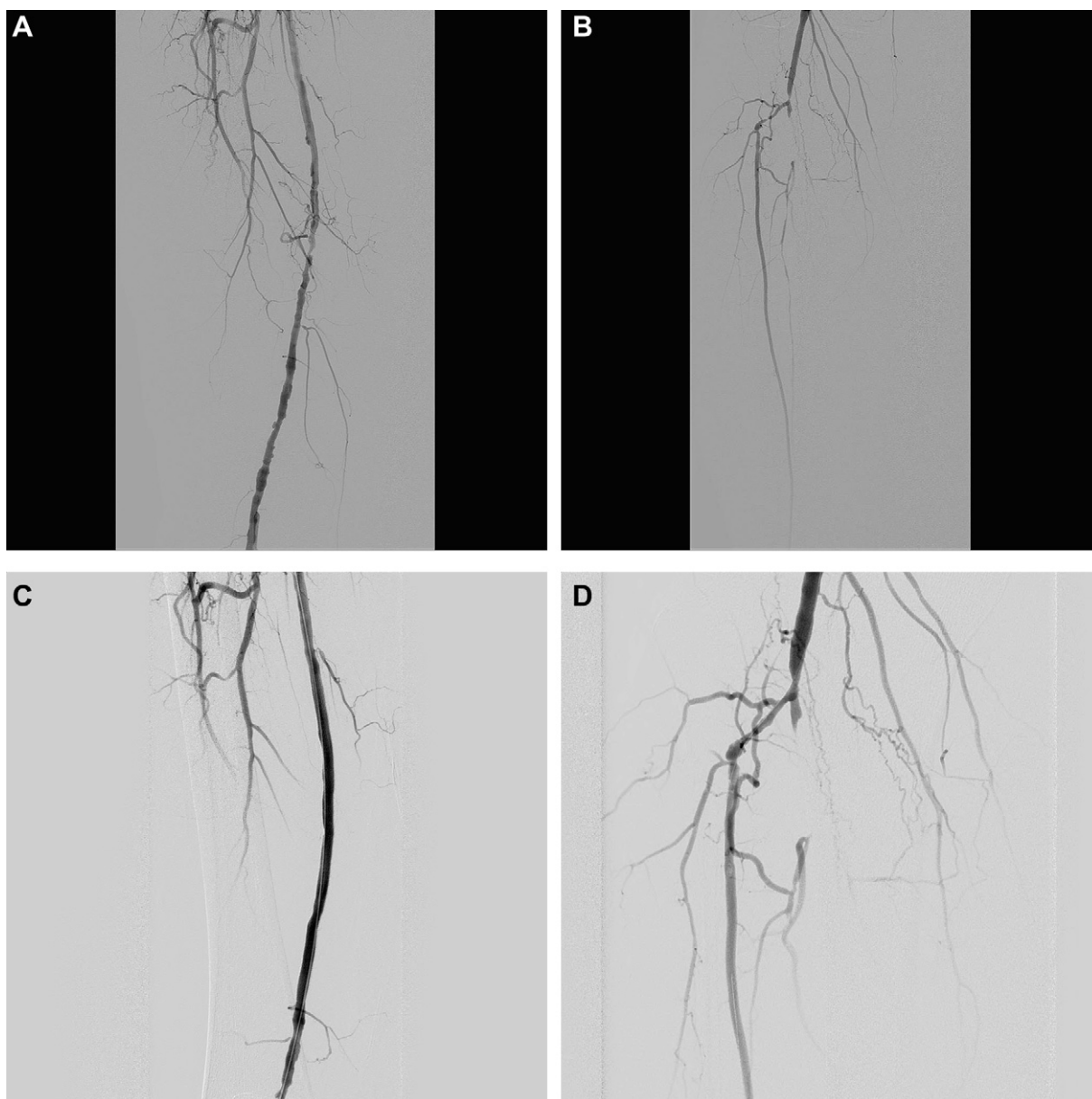


Figure 1 A) and B) pre-intervention angiogram revealing diffuse disease of the superficial femoral artery including several areas of very high grade stenosis and high grade disease in the distal popliteal and proximal anterior tibial artery (single runoff artery), respectively. C) and D) similar views to A) and B) after Viabahn placement in the superficial femoral artery and atherectomy of the popliteal and anterior tibial arteries respectfully.

employed. The entire procedure took 90 min to complete. Piperacillin/tazobactam was administered empirically beginning at admission 4 days before the procedure, but gastrointestinal toxicity prompted a switch to clindamycin and ciprofloxacin after 2 days. Corticosteroids were given for iodine allergy. Methicillin-resistant *Staphylococcus aureus* (MRSA) grew from a blood culture obtained because of fever 1 day after stent graft placement and vancomycin (to which the MRSA was sensitive) was administered for 17 days. Despite a technically successful result with normal triphasic Doppler waveform at the distal anterior tibial artery, foot perfusion was still suboptimal. The anterior tibial was the single patent runoff artery and no named artery crossed the ankle or appeared on the foot so that

direct bypass would not have been expected to enhance perfusion further. The patient suffered progression of forefoot gangrene, repeat angiography confirmed patency of the treated arteries with no apparent options to enhance foot flow and the patient required below-knee amputation.

She was maintained on trimethoprim/sulfamethoxazole (to which the MRSA was sensitive) for 2 months after discharge. Her amputation healed, but she complained of persistent severe pain in the mid-thigh beginning soon after initial treatment. She exhibited no vital sign abnormalities or worsened hyperglycaemia. Ultrasound imaging 5 months after stent graft placement revealed an occluded stent graft, but no fluid collection in the thigh. A fluid collection appeared in the skin and subcutaneous tissue of the medial thigh 6

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