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Aorto-hepatic bypass graft for repair of an inferior pancreatico-duodenal artery aneurysm associated with coeliac axis occlusion: A case report

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ABSTRACT

INTRODUCTION: Inferior pancreatico-duodenal artery (IPDA) aneurysms are very rare and commonly associated with coeliac axis stenosis or occlusion due to atherosclerosis, thrombosis or median arcuate ligament syndrome. We present a case of a surgical repair of an IPDA aneurysm with the use of a supra-coeliac aorto-hepatic bypass with a polytetrafluoroethylene (PTFE) graft, following a failed initial attempt at an endovascular repair.

PRESENTATION: A 75 year old female, who was under investigation for night sweats, was referred to our team with an incidental finding of a 19 mm fusiform IPDA aneurysm. Initial attempt at endovascular coiling of the aneurysm was unsuccessful. Elective surgical repair involved excision of the aneurysm and to restore arterial inflow to the hepatic artery, a PTFE bypass graft was used from the supra-coeliac aorta to the hepatic artery. The patient was well 2 months following the procedure with a patent graft shown on contrast enhanced computer tomography (ceCT).

DISCUSSION: Management options for IPDA aneurysms include radiologically guided endovascular approach or surgical repair. Given the high mortality of greater than 50% with ruptured aneurysms intervention is indicated in all detected cases.

CONCLUSION: Surgical excision with bypass grafting from the supra-coeliac aorta, as reported by our team, represents a satisfactory management option in patients where interventional approaches have failed or are not appropriate.

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1. Introduction

Inferior pancreatico-duodenal artery (IPDA) aneurysms are rare visceral aneurysms that most often represent incidental findings in asymptomatic patients. They can also be detected during investigations for mesenteric ischaemia or in the acute setting due to rupture [1]. Management options include radiologically guided endovascular repair or surgery, with the latter being reserved for those that are not amenable to an endovascular approach [2].

Abbreviations: IPDA, inferior pancreatico-duodenal artery; PTFE, polytetrafluoroethylene; ceCT, contrast enhanced computerised tomography; HPB, hepato-pancreato-biliary; MDT, multidisciplinary team; GDA, gastroduodenal artery; SMA, superior mesenteric artery; HA, hepatic artery.

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We present a case of a surgical repair of an IPDA aneurysm with the use of a supra-coeliac aorto-hepatic bypass with polytetrafluoroethylene (PTFE) graft, following a failed initial attempt at an endovascular repair.

2. Presentation of case

A 75 year old female, who was under investigation for night sweats, was referred to our team with an incidental finding of a 19 mm fusiform IPDA aneurysm, detected on triple phase contrast enhanced computerised tomography (ceCT) of the abdomen and pelvis (Fig. 1). Concurrent coeliac axis occlusion and collateralisation of the arterial inflow to the liver via the IPDA aneurysm was also noted. The patient's medical history was only significant for hypertension and hypercholesterolaemia under medical management.

After discussion in the hepato-pancreato-biliary (HPB) multidisciplinary team (MDT) meeting, an urgent angiography followed by stenting or embolization of the aneurysm was favoured. During the procedure the aneurysm was identified arising from the

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Fig. 1. ceCT illustrating the 19 mm IPDA aneurysm.

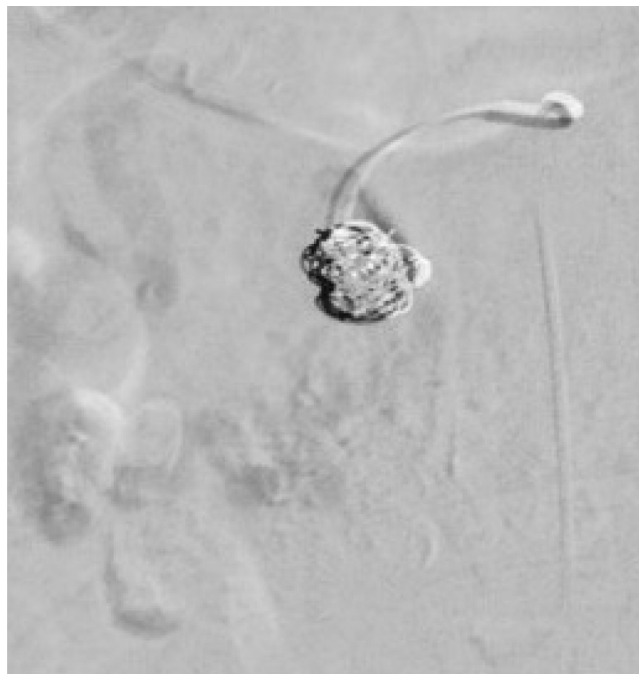


Fig. 3. Microcatheter coil embolization of the IPDA aneurysm.

IPDA at the level of a division of the vessel into two branches, one of which anastomosed with the gastroduodenal artery (GDA) (Fig. 2). As there was no suitable aneurysm neck to undergo liquid embolization, this was performed with multiple interlocking coils (Fig. 3). There were no complications following the procedure and the patient was discharged after 2 days. A follow up ceCT one month later identified that the aneurysm was still partially arterialised. A second endovascular approach was deemed inappropriate by the interventional radiology team due to the complex anatomy and the risks of non targeted embolization of other superior mesen-

teric artery (SMA) branches. The subsequent MDT decision was to proceed with an elective surgical repair due to the risk of rupture.

The procedure was performed with the patient in the supine position through a Mercedes Benz incision. After Kocherisation of

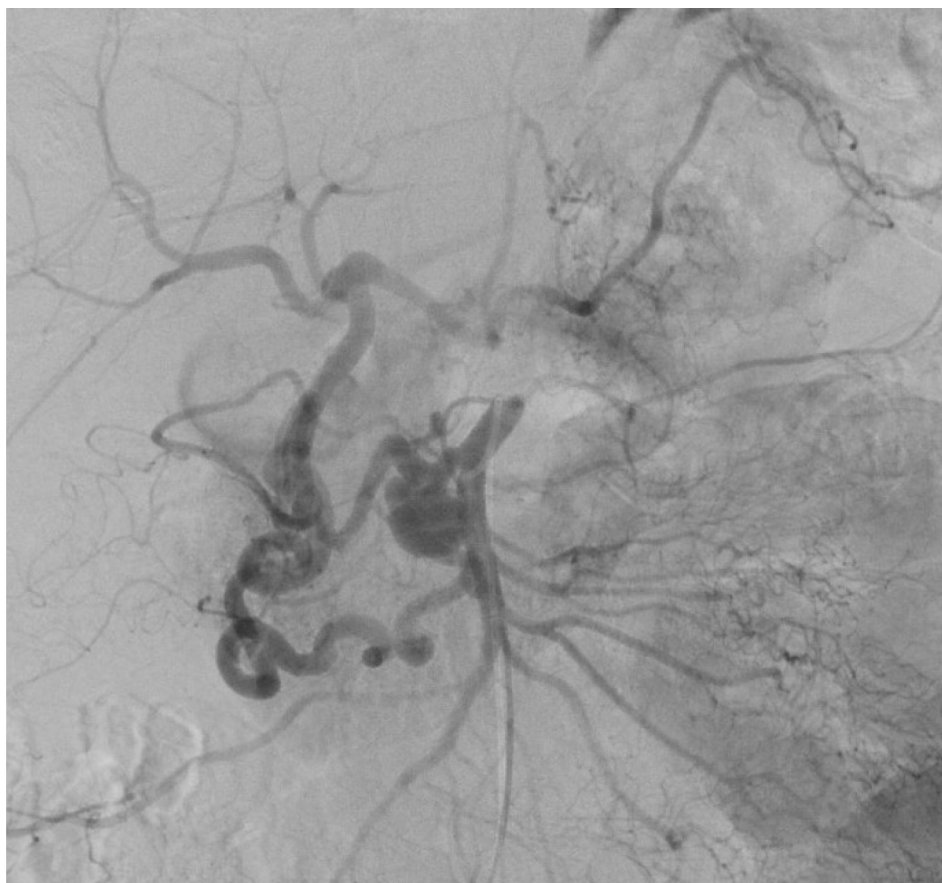


Fig. 2. IPDA aneurysm present at the junction of its division.

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