Late Rupture of a Totally Thrombosed Abdominal Aortic Aneurysm: A Case Report and Literature Review

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Chronic totally thrombosed abdominal aortic aneurysms (AAAs) comprise a rare medical situation, with only a few cases reported in literature. Optimal management has been controversial, although an early risk for rupture is present. Therefore, we present a rare case of late rupture in a patient with a totally thrombosed AAA, and we discuss proper treatment.

Spontaneous thrombosis of an abdominal aortic aneurysm (AAA) is a rare condition, with totally thrombosed AAAs being associated with a continuous risk for rupture according to some authors.[1] Although all the reports in literature refer to an aneurysm rupture within the first year after presentation, no case of late rupture has been reported to date.[2] Therefore, we are presenting a rare case of late rupture in a patient with total AAA thrombosis treated originally with axillobifemoral bypass.

CASE REPORT

A 69-year-old male patient was referred to our emergency department with a diagnosis of a ruptured AAA. His medical history included: arterial hypertension (not adequately controlled with medical treatment), coronary artery disease treated with coronary artery bypass grafting almost 6 years ago (1 year before the diagnosis of the AAA), chronic heart failure (ejection fracture = 30%), cerebrovascular disease, right-sided internal carotid artery occlusion (under dual antiplatelet treatment), left-sided internal carotid endarterectomy, and tobacco and alcohol abuse. Additionally, he had a history of a spontaneously thrombosed AAA (including the common iliac arteries) that presented 5 years ago (original diameter: 5.8 cm; Fig. 1) with symptoms of intermittent claudication. Owing to the severity of the general condition, he had undergone an axillobifemoral bypass in another institution which resolved the symptoms of the peripheral ischemia. However, the patient was lost on follow-up.

On admission, the patient was suffering from severe abdominal and back pain worsening for the last 4 days; he was hemodynamically stable, and a pulsatile abdominal mass was palpated during physical examination. The axillobifemoral bypass was patent with palpable peripheral pulses.

Regarding diagnostic imaging, the patient underwent a computed tomography angiography (CTA) that revealed a ruptured infrarenal AAA (maximum diameter = 7 cm) and confirmed the patency of the axillobifemoral prosthetic graft (Fig. 2). Considering treatment, the patient underwent an emergency laparotomy. After dissection of the retroperitoneal hematoma, we proceeded to division of the left renal vein, exposure and clamping of the infrarenal aortic neck, excision of the aortic sac, and evacuation of the intraluminal thrombus, and finally, we primarily ligated the aortic neck and bifurcation (double layer of sutures). The distal aorta and aortic bifurcation were occluded, and therefore, no in situ reconstruction was considered an option. During declamping, a hemorrhage of the right renal artery orifice presented due to aortic clamp injury and excessive calcification of the aorta. After suprarenal aortic clamping, the deficit of the arterial wall was sutured successfully and aortic clamping was removed, with blood supply to the right renal artery being preserved. Finally, a flap of greater omentum was sutured on the aortic stump for further protection.

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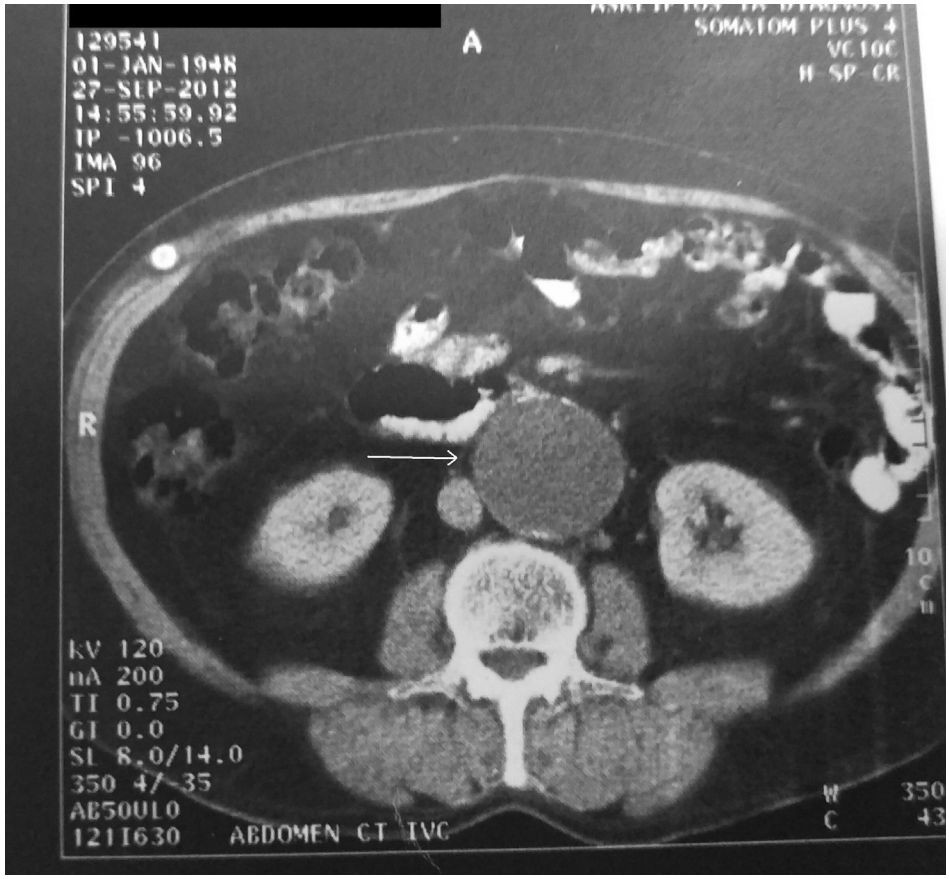

Fig. 1. Computed tomography angiography (CTA) showing a totally thrombosed abdominal aortic aneurysm (AAA, *arrow*) presented 5 years ago.

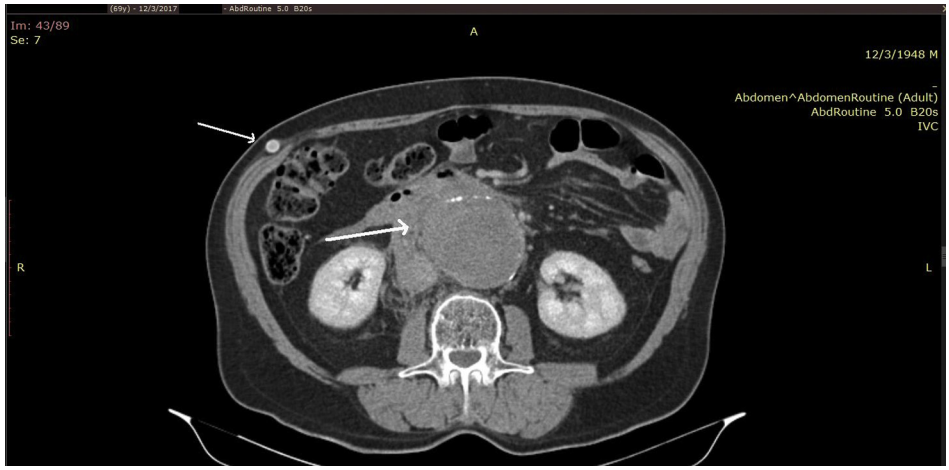

Fig. 2. Computed tomography angiography (CTA) showing a rupture of the aneurysmal sac (*thick arrow*) and the patent axillobifemoral bypass (*thin arrow*).

Postoperatively, the patient was transferred to intensive care unit for further treatment. Postoperative medical treatment included low-molecular-weight heparin prophylaxis, antiplatelet therapy, and intravenous antibiotics (standard prophylaxis for 3 days). Owing to a persistent diarrheal syndrome (even after discontinuation of the antibiotics), the patient was discharged 25 days after the procedure. His course remains uneventful

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