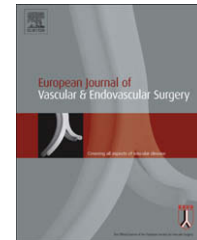




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CORRESPONDENCE

Regarding “Civilini E, Bertoglio L, Melissano G, Chiesa R. Aortic and Esophageal Endografting for Secondary Aortoenteric Fistula. *Eur J Vasc Endovasc Surg* 2008;36(3):297–9”

Dear Editor,

We read with great interest the report of an interesting case of endovascular stent-graft management of a secondary aorto-oesophageal fistula.¹ In this case, apart from gastrointestinal haemorrhage, the patient presented with systemic signs of sepsis. Because the patient was deemed high risk for open surgical repair, and in the setting of haemodynamic instability, we corroborated his urgent management with the less invasive endovascular treatment. Consequently, as there was evidence of persistent leak from the oesophageal lumen into the peri-aortic structures, deployment of a stent-graft within the oesophagus was undertaken, along with percutaneous drainage of the peri-graft collection. Microbiology of the drained fluid revealed positive cultures.

However, scepticism exists regarding the placement of a prosthetic material in an already infected field, and the possibility of persistent/recurrent infection with often devastating consequences remains a concern.² In a systematic review conducted at our institution, aiming to assess the factors associated with poor outcome after endovascular stent-graft treatment of aorto-enteric fistula, it was found that evidence of sepsis preoperatively was a strong factor indicating poor outcome ($P < 0.05$), despite the interruption of the aorto-enteric communication.³ Therefore, we strongly advocate that endovascular repair of the aorto-oesophageal fistula should be a bridge to open surgical repair, when optimisation of the patient's condition has been achieved.

References

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- 3 Antoniou GA, Koutsias S, Antoniou SA, Georgiakakis A, Lazarides MK, Giannoukas AD. Outcome after endovascular stent graft repair of aorto-enteric fistula: a systematic review. *J Vasc Surg* Nov 21, 2008;. doi:10.1016/j.jvs.2008.08.068.

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Response to Letter to the editor re: ‘Aortic and Oesophageal Endografting for Secondary Aorto-enteric Fistula’

Dear Editor,

We appreciate the opportunity to reply to the letter from G.A. Antoniou and A.D. Giannoukas, which raises important issues. We agree that endovascular repair is an emergency bailout procedure to stabilise the patients, improving survival after delayed open surgery. We are pleased to update this case report 16 months after the endoluminal life-saving procedure was performed. At 5 months, the recovery of the patient was satisfactory; however, he stopped the antibiotic therapy 1 month later for reasons that are not clear and soon the fever returned. He was then hospitalised for sepsis at a different hospital.

Through a right thoracotomy and bilateral subcostal laparotomy approach, the patient underwent an oesophagectomy of the segment that included the oesophageal stent-graft and the fistula (Fig. 1) and had a gastric pull-through. An omental flap was wrapped around the thoracic aorta with multiple mediastinal tubes for local irrigation. We gratefully acknowledge Prof. S.M. Giulini and Prof. S.

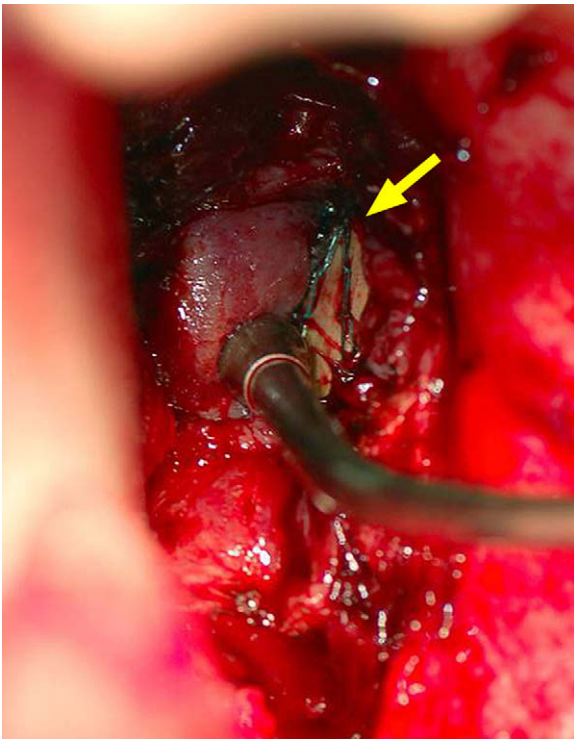


Figure 1 Stent-graft visible (arrow) through the lack of the aortic wall at the level of the fistula after oesophagectomy (courtesy of Prof. S. Bonardelli).

Bonardelli from the University of Brescia for performing this successful operation. The patient was discharged on post-operative day 45.

Four months later, the patient underwent further evaluation: he was afebrile; however, severe weight loss and myelodysplasia were noted, possibly secondary to the antibiotics. He also underwent a complex coronary angioplasty with great clinical improvement. Blood cultures were positive for residual infection by *Escherichia coli*, sensitive to cotrimoxazole. Immediate open aortic surgery was not indicated and the patient is now periodically re-evaluated by the cardiovascular team. Since then, he has gained weight and is considerably better.

When infection involves a prosthetic material, eradication is hardly possible. Lifelong suppressive antibiotic therapy seems to be extremely useful and should not be stopped.

Severe co-morbidities are frequently present in these patients and, even after clinical improvement, the timing of radical open surgery may be really difficult when a satisfactory steady state with best medical therapy is obtained.

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