

# En bloc tibial thrombectomy

Rachelle N. Damle, MD,<sup>a</sup> Hossein Bagshahi, MD,<sup>a</sup> and Donald T. Baril, MD,<sup>b</sup> Worcester, Mass

A 58-year-old man with hypertension and 40-pack year smoking history presented to the emergency department complaining of approximately 20 hours of right lower extremity pain. His initial symptom was short-distance claudication, but quickly progressed to rest pain. Physical examination demonstrated right lower extremity pallor, delayed capillary refill, diminished sensation and strength, with absent femoral, popliteal, dorsalis pedis, and posterior tibial pulses. A pelvic and lower extremity computed tomography angiogram (CTA) revealed occlusion of the right common iliac artery with reconstitution at the level of the right common femoral artery from inferior epigastric artery, total occlusion of the popliteal artery, and no reconstitution distally. After heparinization, he emergently underwent iliac thromboembolectomy. Intraoperative angiography revealed residual thrombus in the proximal right common iliac artery which was treated with the placement of covered stents in the bilateral common iliac arteries. The below-knee popliteal artery was then exposed to address the occlusion seen on preoperative CTA (A). Using a Fogarty embolectomy catheter (Edwards Lifesciences, Irvine, Calif) and a DeBakey forceps through a transverse popliteal artery incision, one contiguous thrombus was removed en bloc, revealing a cast of the tibial trifurcation (B). The vessel was closed primarily and a palpable dorsalis pedis pulse was established. Given the duration of ischemia, a four-compartment fasciotomy was performed. Postoperative workup demonstrated the source to most likely be a large mural thrombus in the visceral aorta (C). He is currently anticoagulated with warfarin. At 6-month follow-up, he reported ambulating near baseline, and had a palpable dorsalis pedis pulse with an ankle-brachial index of 1.1. Additionally, duplex imaging revealed widely patent vessels and follow-up CTA demonstrated near complete resolution of the aortic thrombus (D).

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From the Department of Surgery,<sup>a</sup> and the Division of Vascular and Endovascular Surgery, Department of Surgery,<sup>b</sup> University of Massachusetts Medical Center.

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E-mail: racheddamle@gmail.com.

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