After cutting the ring of the attachment system, the individual stent-struts with hooks can be removed from inside of the aorta without damaging the infrarenal neck. After removal of the attachment frame and graft the aortic balloon is deflated and removed and at the same time an aortic clamp is placed below the renal arteries. This allows a conventional infrarenal anastomosis.

D. Blankensteijn,
Utrecht, The Netherlands

References


No reply received
thoracotomy? The fitness of this patient was proved by the subsequent operations he underwent (femur and mandible repair) and his early discharge home.

The second of the writers of this letter treated a 48 year-old female patient who, following a traffic accident, was unconscious because of brain concussion and contusion. She was found to have bilateral multiple rib fractures with lung contusion and severe pulmonary dysfunction. Because of her condition she had to be intubated. While under mechanical ventilation she underwent successful open repair of the ruptured isthmus (with a Dacron 24-mm tube graft), with the aid of an external temporary axillofemoral bypass graft. The patient was extubated on the 26th postoperative day and was discharged home on the 37th postoperative day. There was no sign of spinal cord ischaemia or renal dysfunction. Although there are recent reports of successful endoluminal repair of descending thoracic aortic aneurysms, there are also complications of such procedures. Thus we believe that deceleration traumatic rupture of the aortic isthmus is still a surgical condition.

A. Gugulakis, P. J. Asimacopoulos and M. N. Sechas

Athens, Greece

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No reply received

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Retroperitoneal Haematoma

Sir,

Whilst we agree with many of the points and conclusions in the article on retroperitoneal haematoma (RPH) after cardiac catheterisation, we were surprised that no mention was made of neurological complications due to the effect of pressure. Several authors have presented such complications, the most common being femoral nerve palsy due either to lumbar plexus nerve roots being stretched within the ilioinguinal muscle or as they emerge from it, or possibly compression of the nerve as it passes under the inguinal ligament. However, neuropathies of the obturator nerve and the lateral femoral nerve of the thigh are also reported, attributed again to lumbar plexus involvement. In a retrospective review of 45 patients with RPH after femoral artery puncture, 36% had signs of femoral neuropathy. Neuropathy may be an acute presenting sign accompanied by systemic features of hypovolaemic shock, and is usually associated with inguinal or thigh pain. However, neuropathy can also develop up to four weeks later and be the only presenting sign of RPH.

There is some evidence that non-operative management may be successful, though this necessitates a significant blood transfusion requirement of over 4 units per patient. At two months 50% of patients still exhibit motor signs, though they almost all resolve by 24 months. However, femoral nerve palsy is a significant, incapacitating disability for the patient, and some have advocated that femoral neuropathy is an indication in itself for surgical intervention. Prompt evacuation of the haematoma and vessel repair relieves these pressure effects on the nerve roots, and may lead to full recovery of function. Sreram et al. reported eleven patients with significant RPH following coronary catheterisation, all requiring operative intervention due to signs of hypovolaemic shock and/or neurological impairment; six patients had acute signs of femoral nerve palsy and two of these showed no improvement even after surgical decompression.

Furthermore, no mention was made of previously reported mortalities due to RPH following femoral artery puncture and cardiac catheterisation, and many of these deaths occurred due to the late recognition of the complication which was alluded to. The lesson is that this is an occult and potentially fatal vascular complication, for which a high index of suspicion is paramount. Lumbar plexus neuropathies may be one of the earliest signs to alert clinicians. Non-operative management is suitable in selected cases, but requires close observation and significant volumes of blood transfusion. Urgent surgical intervention should be considered if the patient fails to improve despite appropriate initial resuscitation by volume replacement, if acute neurological signs are present, or if either supervene with an increased size of RPH on serial CT scans. Interventional radiological treatment may be possible in some cases.

M. A. Tomlinson, A. Anjum and T. Loosemore

St George's Hospital, London, U.K.