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.

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References


Endorepair Conversion

Sir,

In an excellent review article, Drs May, White and Harris have presented four techniques that can be used for conversion from endoluminal to open abdominal aortic aneurysm repair.1 The most important lesson the article brings across cannot be overemphasized: a physician engaging in endovascular aneurysm repair will be confronted sooner or later with a situation in which conversion to open repair can no longer be avoided. I would like to add a little trick that can be used if an endograft with infrarenal hook fixation (EVT/Ancure®, Guidant) needs to be replaced by a conventional graft. In these situations, an infrarenal clamp placed over the hooks of the proximal attachment frame and/or simple caudad traction may seriously damage the infrarenal aorta at the level of a conventional anastomosis.

Suprarenal dissection and clamp placement can be avoided by opening the aneurysm without clamps. After removal of the thrombus from the sac the endograft is exposed and clamped distally. With digital control of the graft proximally, the graft is incised in the mid-portion. A 12-F/50-cc Robicsek–Pruitt aortic occlusion catheter (CryoLife, St. Petersburg, FL, U.S.A.) is then inserted upwards through the opening in the endograft and positioned above the level of the proximal attachment system. Inflating the balloon controls the aorta proximally. The graft is then incised upwards.

Sir,

In the Volume 17, 1, January 1999 issue you published a case report entitled “Traumatic Rupture of the Aortic Arch Treated by Stent Grafting” by N. Lagattola et al.1 There are certain points in this article that we feel need clarification. To begin with the title has little to no correlation with the actual case as it is shown in the two angiograms provided by the authors. As is shown in Fig. 1, the leak is located at the first part of the descending thoracic aorta. Consequently the covered stent (Fig. 2) has been deployed not in the aortic arch but in the descending thoracic aorta. It is true, though, that the proximal part of the stent does extend into the lumen of the aortic arch and partly covers–ocludes the orifice of the left subclavian artery. But the deployment of the stent graft at this area does not justify, in our opinion, the heading “aortic arch stenting”. The authors state that the condition of the patient was deteriorating and because of this they decided to repair the leak endoluminally. In spite of his condition he was able to have his spleen removed, presumably under general anaesthesia, before the endoluminal procedure. He additionally had his femur nailed and the mandibular fracture plated and, as is stated, he was discharged home seven days after the endovascular stent repair. Why is it that a patient is able to undergo surgery for his spleen but not a
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 iliopectineus 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. Sreeram 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.

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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...