Simultaneous Intervention for Coarctation and Aortoarteritis in Same Patient

Lijo Varghese, George Joseph
Christian Medical College Vellore, India

[Clinical Information]
Patient initials or identifier number: 631249F

Relevant clinical history and physical exam:
History: A 62-year-old man presented to the emergency department complaining of sudden onset of numbness of bilateral lower limbs resulting in difficulty in walking. The patient had been previously well except for a history of hypertension and dyslipidemia. Physical examination revealed severe cyanosis of bilateral lower limbs and the pulse of the femoral arteries and distal arteries were not detectable.

Relevant test results prior to catheterization:
An electrocardiogram did not show atrial fibrillation. A huge mass shadow was detected in the left upper lung field in a chest roentgenogram. A computed tomographic (CT) scan of the chest revealed a huge mass (8×13 cm) with lobulated border and necrotic cavities. The tumor extended directly to the left atrium via the pulmonary vein. A transesophageal echocardiography revealed huge mobile masses in the left atrium which protruded into the left ventricle across the mitral valve during diastole. The abdominal aorta was totally occluded down to the common iliac arteries due to possible tumor emboli.

TCTAP C-223
Successful Endovascular Therapy for Acute Limb Ischemia Due to Kinking of Bifurcated Graft for Abdominal Aortic Aneurysm

[Clinical Information]
Patient initials or identifier number: M.G

Relevant clinical history and physical exam:
A 62-year-old man presented to the emergency department complaining of sudden onset of numbness of bilateral lower limbs resulting in difficulty in walking. Physical examination revealed severe cyanosis of bilateral lower limbs and the pulse of the femoral arteries and distal arteries were not detectable.

Relevant test results prior to catheterization:
An electrocardiogram did not show atrial fibrillation. A huge mass shadow was detected in the left upper lung field in a chest roentgenogram. A computed tomographic (CT) scan of the chest revealed a huge mass (8×13 cm) with lobulated border and necrotic cavities. The tumor extended directly to the left atrium via the pulmonary vein. A transesophageal echocardiography revealed huge mobile masses in the left atrium which protruded into the left ventricle across the mitral valve during diastole. The abdominal aorta was totally occluded down to the common iliac arteries due to possible tumor emboli.

Relevant catheterization findings:
An emergency aortography showed a total occlusion of the abdominal aorta at its bifurcation, which was presumed to be due to tumor emboli from the left atrium.

[Interventional Management]
Procedural step:
An emergency embolectomy was performed with hybrid surgical and endovascular intervention using a Fogarty balloon catheter and aspiration catheter through anterograde approach into the bilateral lower limbs. A computed tomographic (CT) scan of the chest revealed a huge mass (8×13 cm) with lobulated border and necrotic cavities. The tumor extended directly to the left atrium via the pulmonary vein. A transesophageal echocardiography revealed huge mobile masses in the left atrium which protruded into the left ventricle across the mitral valve during diastole. The abdominal aorta was totally occluded down to the common iliac arteries due to possible tumor emboli. An emergency aortography showed a total occlusion of the abdominal aorta at its bifurcation, which was presumed to be due to tumor emboli from the left atrium.

[Interventional Management]
Procedural step:
A 62-year-old man presented to the emergency department complaining of sudden onset of numbness of bilateral lower limbs resulting in difficulty in walking. Physical examination revealed severe cyanosis of bilateral lower limbs and the pulse of the femoral arteries and distal arteries were not detectable. A huge mass shadow was detected in the left upper lung field in a chest roentgenogram. A computed tomographic (CT) scan of the chest revealed a huge mass (8×13 cm) with lobulated border and necrotic cavities. The tumor extended directly to the left atrium via the pulmonary vein. A transesophageal echocardiography revealed huge mobile masses in the left atrium which protruded into the left ventricle across the mitral valve during diastole. The abdominal aorta was totally occluded down to the common iliac arteries due to possible tumor emboli. An emergency aortography showed a total occlusion of the abdominal aorta at its bifurcation, which was presumed to be due to tumor emboli from the left atrium.