flow into the left hepatic the common hepatic, the left gastric and the
gastroduodenal and the aneurysm was confirmed occluded.

Conclusions: A the 12-month follow-up, the patient remained symp-
tom free, with patent bypass grafts and complete aneurysm occlusion. The
possible etiologies of multiple aneurysms in a young man will be reviewed
along with treatment approach options.

Endovascular Exclusion to Avoid Aortic Cross Clamping and Facilitate
Removal of an Errant Intravascular Pedicle Spinal Fixation Screw
Javier E. Anaya-Ayala, MD, Benjamin D. Colvard, BS, Christopher J.
Smolock, MD, Zulfiqar F. Cheema, MD, Basel Ramlawi, MD, Alan B.
Lumsden, MD, Michael J. Reardon, MD, Mark G. Davies, MD, PhD, MBA,
Methodist DeBakey Heart and Vascular Center, Houston, Tex

Objective(s): Late presentation of aortic injury by pedicle screws is rare
event. We present a patient with a thoracic vertebral screw implanted 4 years
before presentation that penetrated 90% into the descending aorta and its
subsequent management.

Case report: A 68-year-old woman with history of chronic herniated
disk with compression and myelopathy underwent uneventful thoracotomy,

thoracic discectomy at T7-T8 with decompression at the spinal cord, and
anterior intravertebral arthrodesis at the same level. Four years later she was
seen by her pulmonologist for follow-up on a computed tomography (CT)
scan for a lung nodule; at this time, it was discovered that one of the pedicle
screws was located 90% intravascularly in the descending thoracic aorta. A
CT angiography confirmed that one of the thoracic plate screws on the left
side was traversing the descending thoracic aorta, lying wholly within the
aorta just under the anterior aortic surface. The patient denied symptoms.
She underwent an anterolateral fourth intercostal redo thoracotomy. After
the lung was mobilized, the aorta was exposed proximally and distally to the
level of the screw. Thereafter, both femoral arteries were accessed under
ultrasound imaging, and an aortogram demonstrated satisfactory vessels up
to the aortic arch. The patient underwent placement of a 24 × 11.5 Talent®
Endoluminal Stent-Graft (Medtronic Inc, Santa Rosa, Calif) excluding the
intravascular portion of the screw from blood flow. An aortotomy was
performed, and the hardware was removed in a bloodless field. The aorto-
tomy was closed and the stent fully expanded along its entire length. The
patient was discharged 5 days later in stable condition.

Conclusions: This case illustrates the benefit of endografting to avoid
aortic cross-clamping, aortic interposition grafting and the attendant se-
quelea of such surgery.