Conclusions: Aortoduodenal fistula is a seldom-encountered condition with high morbidity and mortality; successful treatment requires prompt diagnosis and intervention.

Fig.

Popliteal Artery Pseudoaneurysm Resulting from Osteochondroma of the Femur in a Pediatric Patient

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Objectives: Popliteal artery pseudoaneurysms resulting from osteochondromas are rare but reported cases. We present a case of a young patient in which a true exostosis of the bone was not found to be the culprit.

Methods: A 6-year-old boy presented with a two week history of pain in his left leg and a large mass in the thigh. On exam, his leg was contracted at the knee. A large pulsatile mass was palpable in the medial thigh with absent pedal pulses. Imaging including duplex ultrasound and CT scan revealed a 7 cm pseudoaneurysm arising from the above knee popliteal artery with near occlusion of the lumen. Aggressive physical therapy was undertaken prior to surgery in order to relieve the contracture.

Results: A medial approach was used to expose the above-knee popliteal artery. The artery was found to be displaced posteriorly and compressed. The defect in the vessel was identified and the compressed artery was resected. A bypass was performed using reversed greater saphenous vein interposition. Inspection of the femur did not reaveal a definite osteophyte as the cause. This was confirmed with intra-operative xray. However, there was an area of eroded bone that was presumed to be the culprit and was covered with the pseudoaneurysm capsule. At follow-up, the patient had palpable pedal pulses and was ambulating well.

Conclusions: Our 6 year old patient is the youngest reported case in the literature. In most cases, an osteophyte can be found as the inciting cause. However, in this case, no osteophyte was found. Instead, an area of erosion of the distal femur was the culprit. In cases where the popliteal artery is compressed, simple suture repair or patch angioplasty may not be definitive treatment. Our patient required a bypass to repair the damaged popliteal artery due to compression from the pseudoaneurysm.

Hybrid Repair of an Infected Carotid Artery Pseudoaneurysm in a High-Risk Patient

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Background: Infected carotid artery pseudoaneurysm (CAP) is a rare complication following carotid endarterectomy. Continued risk of expansion and rupture necessitates urgent repair. Surgical therapy for infected CAP can be challenging with associated risk of disabling stroke and death. Recent reports in the literature describe endovascular therapy as a safer alternative to repair of infected CAP.

Methods: Case report and review of pertinent English-language literature.

Results: We describe the case of a 74-year-old female with a history of previous primary and redo carotid endarterectomy, and subsequent carotid artery angioplasty/stent placement for recurrent stenosis. She presented with a sentinel bleed from a carotid-cutaneous fistula and required emergency intervention. Our operation included hybrid endovascular therapy to exclude the pseudoaneurysm with a commercially available polytetrafluroethylene (PTFE) covered stent and coil embolization of the external carotid artery from a low cervical approach, as her anatomy would not allow for a transfemoral approach. Two days later the patient underwent surgical excision of all infected tissue in the neck, including the infected Dacron patch, and closure of the neck with an ipsilateral trapezius myocutaneous flap. The postprocedure course was uncomplicated and the patient was discharged on clopidogrel and oral antibiotics.

Conclusions: This case report provides additional data as to the safety and efficacy of stent graft treatment of infected CAP.

Fig.

Femoral-Femoral Stabilizing Wire for Embolization of the Internal Iliac Artery

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Objectives: Hypogastric artery embolization is performed in a variety of clinical scenarios, most commonly in patients undergoing endovascular aneurysm repair (EVAR) with an iliac artery aneurysm or inadequate distal landing zone. In these patients, internal iliac artery embolization with iliac limb extension is often performed. Hypogastric embolization may be particularly challenging in patients with an acutely angulated aortic bifurcation or in patients with short or ectatic common iliac arteries. Hypogastric artery embolization can be time consuming and lead to increased radiation exposure and contrast administration. Having a sheath precisely positioned and stabilized at the internal iliac artery origin will facilitate embolization of the hypogastric artery. This report describes a novel technique in which crossover femoral-femoral artery wire placement achieves stable positioning of large sheaths for concurrent hypogastric embolization at the time of EVAR.

Methods and Results: Four male patients with a mean age of 80 years underwent endovascular repair of aorto iliac aneurysms with adjunctive coiling of the hypogastric artery. Difficulties with hypogastric artery cannulation due to anatomy was anticipated in all patients due to large common iliac aneurysms (diameter range of 4-11 cm), short CIA (n = 1), wide aortic bifurcation (n=1), and severely ectatic iliac artery (n = 1). Large caliber sheaths (9-12 Fr) were placed over the aortic bifurcation (Fig, *A*) on a stiff wire which required a successful snaring of the wire in distal aorta. A femoral-femoral cross over wire of either 0.014″ or 0.035″ was used to