

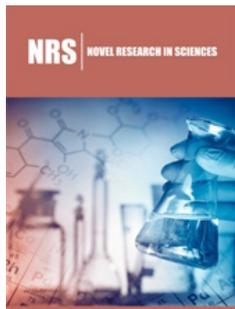
# Case Report: Abdominal Aortic Aneurysms

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## Abstract

Abdominal Aortic Aneurysms (AAA) more commonly affect men and are estimated to affect 4% to 8% of men older than age 60 years. There are two methods of repairing AAA, Open surgical repair and Endovascular repair. While surgical treatment for Abdominal Aortic Aneurysm (AAA) is a standard operation, prevention of complication is important. One of these complications is Aneurysmal dilatation at the anastomotic site or recurrent AAA.



## Background

This is a case presented to our institution complaining of diarrhoea and other nonspecific gastrointestinal symptoms. On further investigation, we discovered 12cm dilatation of the aorta after open surgical repair for AAA done about 6 years back.

**Abbreviation:** AAA: Abdominal Aortic Aneurysm

## Case Discussion

75 years old male was admitted to the medical ward with 1 week history of diarrhoea and fatigue. Unable to get out of bed. Dehydration with renal impairment and electrolyte abnormality, mild anaemia and low folate and was diagnosed provisionally with bacterial gastro-enteritis. He is known to have emergency repaired AAA in 2014 using a 20mm Vascutek graft for leaking AAA. Background of Hypertension, Diabetes Mellitus type 2, Atrial Fibrillation on Apixaban, vascular/Alzheimer dementia and high cholesterol. Surgically, he had undergone Laparoscopic incisional hernia repair 2016, and conservatively managed traumatic L2 spine fracture. During investigation, with CT abdomen and pelvis, he was found to have recurrent infra renal AAA reaching 12cm in its maximal diameter with no evidence of leak or rupture. At this point, given his age and hints of co-morbidities and the previous incisional hernia repair, it was opted against open surgical repair and was decided to perform EVAR [1-3].

Unfortunately, this patient was followed up in the outpatient vascular clinic for only two years post operatively after which he lost the follow up appointments. On the proposed day of surgery, and under general anaesthesia, EVAR was done with no complications, during the procedure the right IMA was coiled.

The patient was then transferred to rehabilitation after 12 days, where he stayed for about one month and discharged home. During that period, he was complicated with HAP which has been managed with Antibiotics [4,5].

## Discussion

Open surgical repair is the standard operation for AAA. Complications occurring with AAA repair include but not limited to, Aneurysms at anastomosis site, Ischemic colitis, Renal failure, leak or rupture at anastomotic sites, among others [6]. Previous surgical history involving abdominal surgeries make open repair very challenging. Same as comorbidities do. When this is the case, EVAR is a very good solution with fewer complications and faster recovery. The problem is that there are anatomical limitations for EVAR to be suitable, together with

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availability of intervention radiology and definitely the appropriate resources. AAA can present with many clinical pictures, and health care professionals should keep this diagnosis always in mind. In our case, AAA was picked incidentally, with fall down and lumbar fracture in the first presentation when he was found to have leaking AAA [7]. And in the second presentation, he presented with infective diarrhoea, and the AAA was picked incidentally by a CT abdomen and pelvis to search for undiagnosed tumour [8,9].

### Conclusion

OAS carries a significant reintervention rate. EVAR is a good bailout option for repairing recurrent AAA especially when there are multiple co-morbidities and or previous abdominal surgery.

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