

Large Saccular Descending Thoracic Aortic Aneurysm: An Unexpected Cause of Cardiovascular Syndrome

Büyük Sakküler İnen Torasik Aort Anevrizması: Kardiyovokal Sendromun Beklenmeyen Bir Nedeni

A 63-year-old male patient presented with moderate-intensity chest pain and dyspnea for the past three months, along with hoarseness for the last 10 years, which had worsened over the previous two months. He had a history of uncontrolled hypertension for 20 years. He had previously been admitted to another hospital, where a mediastinal mass was suspected based on a chest X-ray (Figure 1). Echocardiography showed moderate aortic regurgitation with a preserved ejection fraction. Computed tomography (CT) angiography revealed a saccular descending thoracic aortic aneurysm (DTAA) with a large surrounding intrasaccular hematoma, diameter of aneurysm was approximately 76.5 mm, with neck size 23.4 mm. (Figure 2). We also diagnosed cardiovascular syndrome caused by the large saccular DTAA. After careful consideration, an interventional procedure with thoracic endovascular aortic repair

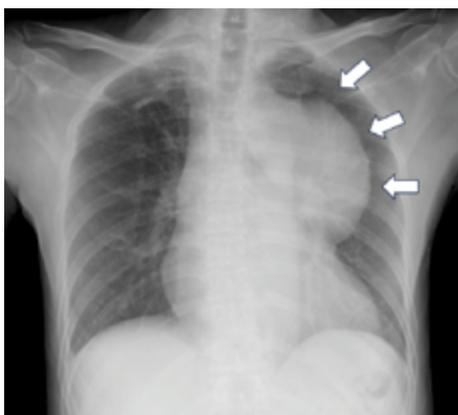


Figure 1. Chest X-ray image of the patient.

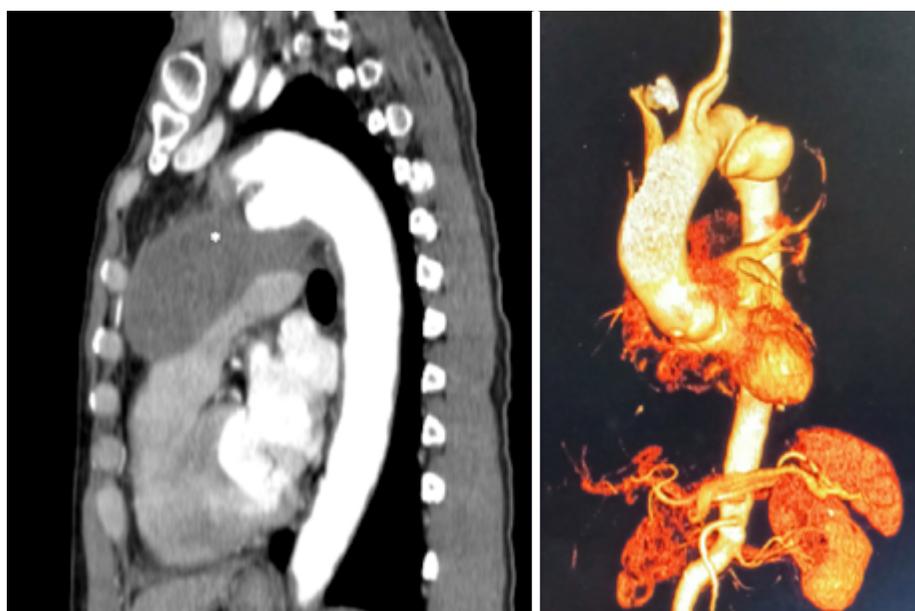


Figure 2. Computed tomographic angiography images of the patient showing a saccular descending thoracic aortic aneurysm (DTAA), including sagittal and oblique sagittal views with three-dimensional (3D) volume reconstruction.

CASE IMAGE OLGU GÖRÜNTÜSÜ

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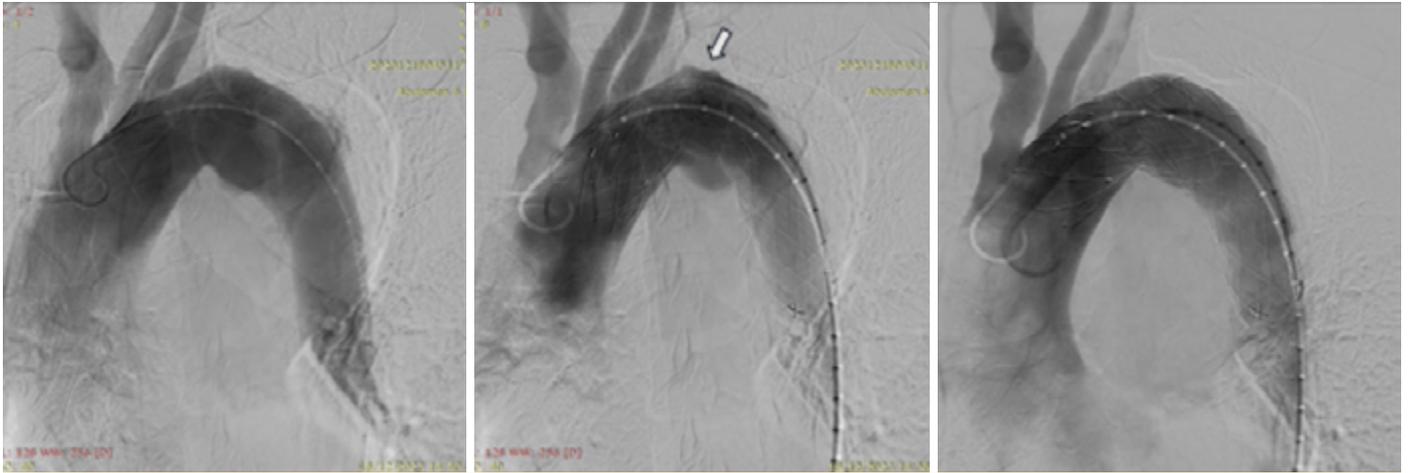


Figure 3. Aortography images of the patient during the thoracic endovascular aortic repair (TEVAR) procedure.

(TEVAR) was chosen, using a self-expandable nitinol-covered stent (HERCULES 34 x 130 mm, S&G Biotech, South Korea). After stent deployment, a type IA endoleak was observed. Post-stent balloon dilatation using a catheter balloon (GIANT S 10 x 46 mm, Scitech Medical, Brazil) was performed to seal the endoleak and achieve optimal stent oversizing for aneurysm endoclosure (Figure 3). No major post-procedural complication occurred, except that the patient, unfortunately, developed slight hemiparesis of the left extremities during the one-month follow-up period and unilateral right leg claudication during the two-month follow-up period. A diagnosis of iatrogenic rupture with thrombotic occlusion at the right common femoral artery (CFA) was made from CT arteriography, and the condition was successfully managed with femorofemoral bypass grafting. In this case, TEVAR may be an effective and safe treatment for

saccular DTAA in elderly patients. Post-TEVAR surveillance is essential to detect late complications following the procedure.

Informed Consent: Written informed consent was obtained from the patient and the family.

Peer-review: Internally peer-reviewed.

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