

When a surgical approach is more favorable

We are grateful to Pham and Le¹ for sharing such an interesting case of a patient with a rare congenital anomaly of the common iliac arteries affected by an abdominal aortic aneurysm (AAA). In our opinion, this setting is challenging for a vascular surgeon, and it highlights some interesting aspects we would like to discuss.

We wondered why the authors had decided to treat an AAA with a maximum transverse diameter of <55 mm. The authors wrote that a 65-year-old man was transferred to the vascular surgery department for management of an infrarenal AAA. His medical history included hypertension and a colectomy combined with protective ileostomy to treat a colonic perforation. Because it was not possible to assess the subject as a high-risk patient, why not opt for open repair? The abdomen was hostile for median transperitoneal access to the aorta, but what about performing a left lombotomy retroperitoneal access? Reaching the right iliac artery and its bifurcation with this access is usually arduous. Nevertheless, it would have been feasible to clamp the external and hypogastric iliac arteries using a balloon catheter. Thus, extensive dissection would have been avoided, and the patient's congenital anatomy would have simplified the access to the right iliac bifurcation.

In the authors' comments, a surgical option was considered but then discarded owing to the presence of the hostile abdomen and because an "endovascular repair could also be a suitable alternative." Because the reference standard treatment of an AAA is still open surgery, it is reasonable to suggest open surgical repair as the first strategy for younger, fit patients with a long life expectancy.²

The endovascular planning devised by the authors, including the left iliac branch deployment in the right short limb of the aortic main body, would have been a brilliant, yet remarkable, choice for a high-risk patient. However, it entails the occlusion of the right internal artery; this is an extremely critical point for dramatic colic

ischemia in a young patient already devoid of the inferior mesenteric artery.

In our view, the best long-term option for this patient would have been a bifurcated surgical graft on hypogastric arteries with reimplantation of the external iliac arteries on the prosthetic branches.

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