Case Report

Leaking abdominal aortic aneurysm mimicking ureteric colic: So rare but so real in Middle East

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Abstract Aortic aneurysms are very rare in Middle East unlike Europe and America. Therefore, this pathology is very likely to be missed in acute presentation to the Emergency Medicine Department. We present a case of leaking abdominal aortic aneurysm mimicking right ureteric colic, which was missed in the initial assessment.

Key Words: Acute aortic dissection, computerized tomogram, Emergency Medical Department

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INTRODUCTION

Aortic aneurysms are very rare in Middle East. Sometimes presentation is very close to ureteric colic, so they are likely to be missed. We present a case of leaking abdominal aortic aneurysm mimicking right ureteric colic, which was missed in the initial assessment. Our case report will help emergency physician and urologist to remember this life threatening condition as one of differential diagnosis in high risk patients.

CASE REPORT

A 61-year-old male Bahraini who was smoker and known case of hypertension and dyslipidemia, presented twice in the Emergency Medical Department (EMD), with acute right loin pain radiating to groin. Pain was moderate with a score of 5/10, continuous with little dysuria. In EMD, his blood pressure (BP) was 148/90 mmHg and varied between 118/66 and 179/148 mmHg during admission. His heart rate (HR) was 76/min. Rest of the vitals were stable. Examination was unremarkable. Creatinine was 124.7 μmol/L. His hemoglobin was 10.4 g/dl and remained stable. His white blood cell count was raised to 16.56 × 10^3/μL (range 3.6–9.6) and urine revealed 18–20 red blood cells. He was admitted with a provisional diagnosis of right ureteric colic. Noncontrast computerized tomogram (CT) was reported negative for urolithiasis, but positive findings were gallstones, enlarged left suprarenal gland with large retrocaval and paraaortic lymph nodes along with spondylolysis L4–L5 vertebra [Figure 1]. Hence, contrast CT was done which reported aortic aneurysm arising from right lateral wall of distal aorta measuring 2.5 cm × 2.5 cm with its neck measuring 1.1 cm associated with hyperdense area 5.6 cm × 5.4 cm × 3.2 cm on its right side with no active contrast extravasation along with left adrenal adenoma 1.2 cm in size along with paraaortic lymph node 2 cm in size [Figure 2a and b]. Vascular team was informed immediately and patient was shifted under their care with stable vital signs and BP of 129/80 mmHg and HR of 62/min.

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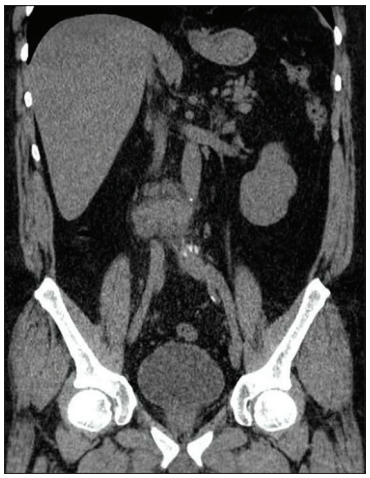

Figure 1: Coronal view of computerized tomogram

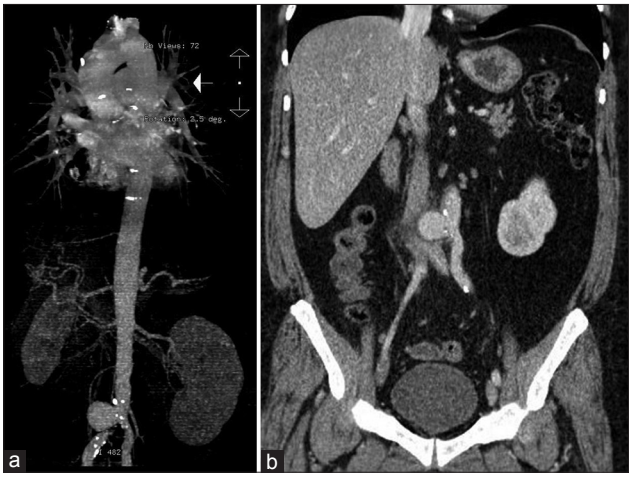

Figure 2: (a) Reconstruction view. (b) With contrast

DISCUSSION

Incidence of acute aortic dissection (AAD) is 0.3% in patients attending EMD with complaint of back pain.[1] AAD is notorious for being missed as it can mimic many other acute conditions.[2] It can be missed in up to 38% patients on initial assessment and is found on postmortem examination in up to 28% of patients.[3] AAD is a life-threatening emergency and delay in diagnosis and treatment has serious consequences with very high mortality of 1–2%/h of delay.[4] The clinical predictors or risk factors are hypertension, Marfan syndrome, male sex, and advanced age.[5] Smoking is associated with 3–5 times increased risk of having aortic aneurysms.[6] There is no single diagnostic modality which can accurately diagnose AAD. However, contrast CT is the best with 92%–96% diagnostic accuracy.[7]

CONCLUSIONS

Leaking abdominal aortic aneurysm is very rare but a real possibility in Middle East as we have seen in our case. Even in western world, where it is more common, it is missed in about one-third of cases, resulting in a very high mortality. Hence, it must not be forgotten and should always be included in the differential diagnosis, especially if risk factors exist.

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Conflicts of interest
There are no conflicts of interest.

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