CLINICAL PRACTICE
*Clinical Images*

# Leriche Syndrome

*Michael Frederick, MD*[1], *John Newman, MD, PhD*[1], *and Jeffrey Kohlwes, MD, MPH*[2]

[1]University of California San Francisco, Veteran's Affairs Medical Center, San Francisco, CA, USA; [2]University of California San Francisco, Veteran's Affairs Medical Center, San Francisco, CA, USA.

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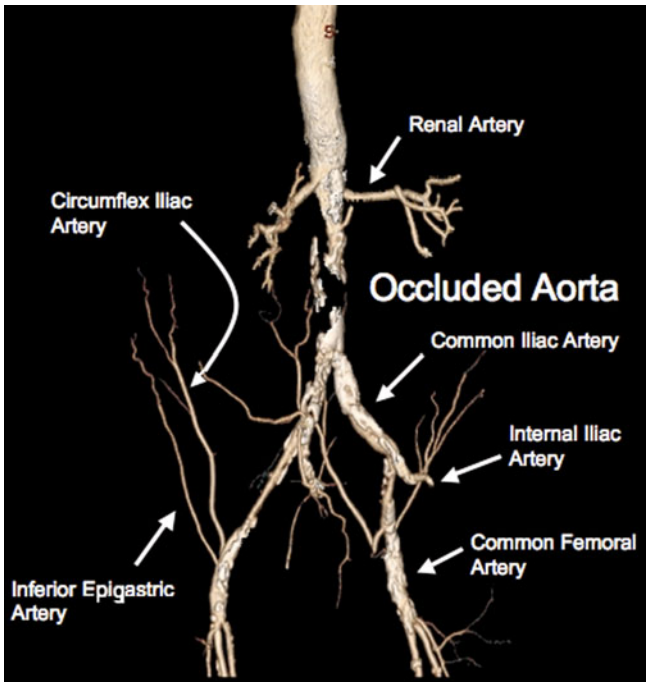
A 58-year-old man was admitted for coronary angiography after several months of worsening angina. After two failed femoral catheterization attempts due to guide-wire obstruction, access was achieved through the right brachial artery. Catheterization revealed severe three-vessel coronary artery disease. An aortogram was performed revealing a complete occlusion of the aorta inferior to the renal arteries. A computed tomography angiography with runoff demonstrated significant collateral circulation with reconstitution of the distal femoral arteries. (see image 1)




On further history, the patient noted bilateral calf and buttock claudication, erectile dysfunction and a 40-pack year smoking history. Despite complete aortic occlusion, the patient had 1+ palpable posterior tibial and dorsalis pedis pulses due to extensive collateralization. (see image 2)

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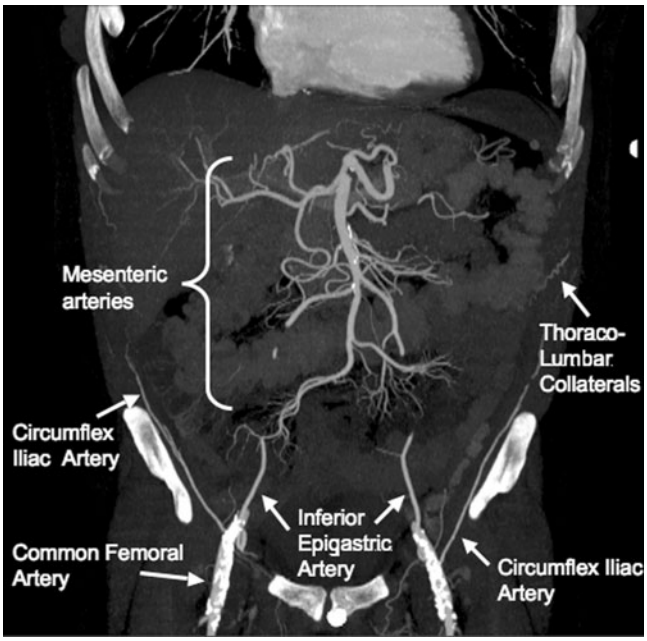


Leriche syndrome is the triad of claudication, impotence and decreased pulses due to aortoiliac occlusion.[1] Risk factors include hyperlipidemia, hypertension, diabetes mellitus and smoking. The Ankle Brachial Index is a non-invasive, inexpensive and reliable method to screen patients.[2] Treatment is aimed at relieving the symptoms related to aortic occlusion as well as the prevention of proximal propagation of thrombus. Complete aortic occlusion is treated with open bypass surgery although new endoscopic techniques are on the horizon.[3] Our patient had a successful three vessel CABG followed 2 months later by aortofemoral bypass. His claudication completely resolved 3 weeks postoperatively.

***Conflict of Interest:*** *None disclosed.*



***Corresponding Author:*** *Michael Frederick, MD; University of California San Francisco, Veteran's Affairs Medical Center, 333 Hugo St, San Francisco, CA 94122, USA (e-mail: Michael.Frederick@ucsf.edu).*

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