A 65-year-old man with chronic lumbar pain and changes in aortography

Vitorino Modesto dos Santos [1]
Hermano Alves Araujo [2]
Lucas de Souza Poletti [3]

1 Internal Medicine of Catholic University and Armed Forces Hospital (HFA), Brasília-DF, Brazil.
2 Vascular Surgery Division of Armed Forces Hospital (HFA), Brasília-DF, Brazil.
3 Medical Resident of SES-GDF, Brasília-DF, Brazil.

Correspondencia: Prof. Dr. Vitorino Modesto dos Santos
E-mail: vitorinomodesto@gmail.com

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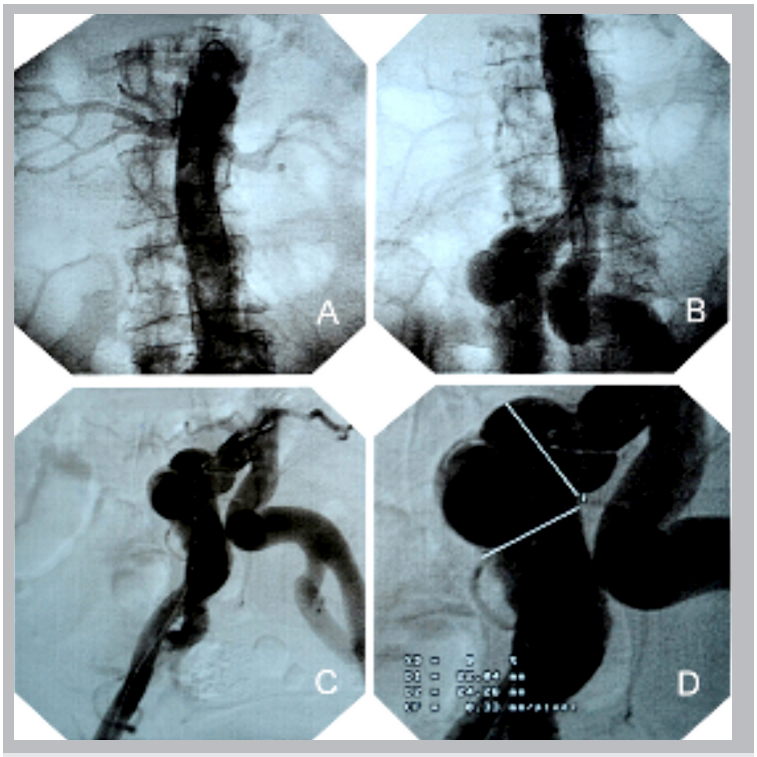

Figure 1. A to **C**: characteristic findings of aneurysm affecting the right iliac artery; and **D**: site of placement of the clamps for interposition of the arterial graft utilized in surgical correction

The patient

A 65-year-old male with medical history of hyperlipidemia, type 2 diabetes mellitus, and arterial hypertension well controlled by glibenclamide, and amlodipine plus enalapril for about a decade was referred to our service because of the recent findings in aortography (**Figure 1: A, B, and C**). He was not a smoker, neither a heavy alcohol drinker, and had chronic lumbar pain related to degenerative spondyloarthropathy. Previous imaging studies had showed narrowing of the disc space and reduction of the diameter of spinal canal on L4 and L5. During evaluation of control, an incidental image was observed in the right side of his pelvis, and the aortography was done. On presentation, BMI was 33 kg/m², temperature was 36°C, blood pressure was 120x80 mmHg, with 80 bpm and 14 irpm, and there were no significant physical findings on abdominal region. Laboratory findings (normal ranges) revealed unremarkable blood counts and thyroid function; total cholesterol 289 (<200 mg/dL), HDL 54 (30-60 mg/dL), LDL 206 (100-190 mg/dL), and tryglicerides 147 (<180 mg/dL); glucose 70 (70-99 mg/dL), uric acid 8.7 (2.5-7.0 mg/dL), urea 57 (14-50 mg/dL) with creatinine clearance 129.6 (≥129 ml/min); and PSA 0.5 (<4.0 ng/mL). After a successful open invasive procedure, he was discharged to outpatient follow-up. What is your diagnosis?

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The diagnosis

Isolated iliac artery aneurysm

Commentary

Isolated iliac artery aneurysm (IAA) is a quite rare condition, with estimated prevalence ranging between 0.008 and 0.03% of the population [1, 2]. Isolated IAA accounts for approximately 0.04% of the aortic-iliac aneurysms [3], and might constitute up to 7% of all the intra-abdominal aneurysms [1]. In our patient, the atherosclerotic aneurysm was due to hypertension, diabetes and dyslipidemia; other risk factors are Marfan and Ehler-Danlos syndromes, trauma, syphilis, and pregnancy [1-3]. The diagnosis of this entity was incidental, based on routine imaging studies for bone changes, an occurrence that is frequently described in patients with nonexistent or unspecific presentations [1]. Additionally, to a variable modality of abdominal, groin, hip or buttock pains, the presenting symptoms of IAA may mimic diverse gastrointestinal, neurological, and urological disorders. Therefore, these aneurysms can evolve unsuspected till achieve larger sizes before diagnosis; such possibility may involve increased risk of acute rupture with an elevated mortality rate [1-3]. Because this iliac aneurysm presented over than 4cm in diameter, our surgical option was open interposition of a surgical graft, which remains the gold standard of management in this setting [3]. Aneurismectomy was done, as showed in image 1D, using an aortic-iliac bypass with Dacron graft; post-operative course was uneventful and the pulsation of the lower limb persisted good. Worthy of note, the patient's chronic lumbar osteoarticular pain lessened but did not disappear. Actually, the patient herein described had previous confirmed diagnosis of degenerative vertebral changes; the concomitance of these conditions has been a common cause of diagnostic pitfalls. Although rare, IAA involves the risk of serious prognosis, mainly related to acute rupture [1-3]. Primary care physicians must have this entity in mind when evaluating causes of sciatic pain, because early diagnosis and prompt adequate management are associated with better outcomes.

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Conflict-of-interest

The authors have no conflict of interest to disclaim.

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Author contributions

The authors contributed equally in this report.

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