Completely occluded aorta associated with coronary heart disease

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We present a 55-year-old patient, with a history of essential hypertension and heavy smoking habit. He was also followed up due to chronic ischaemia of lower limbs IIb of the Fontaine classification.

He was referred for effort angina (CCS III) within the past months. A stress echocardiography demonstrated inferior–posterior–lateral ischaemia and normal ejection fraction. Thus, a scheduled coronary angiography was developed, by radial access, showing left main and three-vessel disease (Panel A) with a chronic total occlusion of the right coronary artery (Panel B). A triple coronary arterial bypass grafting was performed.

During his stay, the patient complained of resting pain localized in both lower limbs, with abolished femoral pulses and erectile dysfunction. Computed tomography was performed, revealing complete thrombosis of the infrarenal aorta (Panels C–E). Perfusion was maintained by collateral branches in femoral arteries and in all major abdominal visceral branches. The patient underwent bilateral axillofemoral bypass successsfully.

The usefulness of screening for coronary disease in patients with peripheral vascular disease (PVD) is well known, since both are part of the clinical spectrum of atherosclerosis. Due to the high surgical risk associated with coronary disease, its treatment must be performed prior to vascular surgery. However, it is not so standardized the screening for PVD in patients who complain of angina. This case, while extreme, illustrates that collaterals may evade the diagnosis of PVD and the need for systematic research to formally rule out PVD in coronary patients.

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