

# Psoas abscess complicating endovascular aortic aneurysm repair

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## ABSTRACT

Aortic stent graft infection is a rare but serious complication associated with high mortality. This report emphasizes the need for continued awareness of potential graft-related septic complications in patients undergoing Endovascular Aortic Repair (EVAR). We report a case in which a post-EVAR patient became unwell about 30 days post operatively and was shown on CT scanning to have a psoas abscess. The abscess was managed with percutaneous drainage and antibiotics. The patient remains well with no evidence of psoas collection or perigraft infection one year on. We review the available literature and discuss the merits of different management strategies.

## INTRODUCTION

Endovascular Aneurysm Repair (EVAR) is now well established as treatment option for abdominal aortic aneurysms (AAA). Up to 70% of all infrarenal AAAs are now treated endovascularly. Like all other surgical procedures that involve the implantation of non-degradable prosthesis, stent-graft infection is a dreaded complication, but it is fortunately rare.

Although there is no convincing evidence, it is generally accepted that the incidence of aortic graft infection is higher with open repair (OR) than with EVAR. Once established infected aortic grafts can lead to bacteraemia, para-aortic abscesses, psoas abscess and aorto-enteric fistulae. Operative intervention is usually required to remove the infected graft. A variety of reconstruction options are available to re-establish arterial flow to the pelvis and lower limbs. About 1.4% of infected aneurysms are complicated by psoas abscess formation (1).

We report a case in which an otherwise uneventful EVAR was complicated a month later by development of a psoas abscess. We discuss our management strategy and review other management options as detailed in the literature.

## CASE REPORT

An 82 year old gentleman with known peripheral vascular disease and previous open popliteal aneurysm repair underwent endovascular repair of a 58mm infrarenal abdominal aortic

aneurysm (Fig. 1) using a Cook Zenith bifurcated prosthesis The Zenith Flex® AAA Endovascular Graft (Cook Medical Inc., Bloomington, USA). The operation, which was performed under general anaesthetic and bilateral groin cut downs with intravenous prophylactic antibiotic cover on induction (Co-amoxiclav 1.2g) was uneventful. The main body was deployed via the right side. Completion angiograms showed satisfactory exclusion of the aneurysm sac with good graft position and no endoleaks. Post operatively the patient had a brief period of low grade pyrexia and lower abdominal pain that settled spontaneously. This was thought to be due to post implant graft reaction. Pre-discharge imaging with plain abdominal X-rays was deemed satisfactory.



Four weeks following discharge the patient was re-admitted with feeling increasingly unwell, recurrent pyrexia, loss of appetite and mild shortness of breath on exertion. Physical examination was unremarkable except for a temperature of 38.3 centigrade. Blood tests on admission showed Hb 11.4 g/dl (11.5-16.0 g/dl), white cell count 13.1x10<sup>9</sup>/L (4-9.2 x 10<sup>9</sup>/L) and CRP 68mg/L (