Fever and haematochezia: an unusual association

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DESCRIPTION

A 72-year-old male patient presented to the emergency room for haematochezia followed by syncope. In the past 2 days he had fever and asthenia. From his medical records, we registered a peripheral vascular disease, with an aortobifemoral bypass graft placed 12 years prior; 6 years later, the graft had a thrombosis event and the patient was submitted to an axillofemoral bypass graft. On physical examination, he had haemodynamic instability and fever (38°C); the abdominal examination showed no abnormalities. Laboratory tests were as follows: haemoglobin: 10.7 g/L, white cell count: 17.7×10^9/L; international normalized ratio (INR): 6.26; C reactive protein: 202 mg/L; blood urea nitrogen (BUN): 44 U/L; and creatinine: 1.91 mg/dL.

After haemodynamic resuscitation, given the clinical presentation and the hypothesis of secondary aortoenteric fistula (AEF), a CT angiography was performed (figure 1). Although no active bleeding was detected, the aortobifemoral bypass graft was found to be adjacent to the third part of duodenum, but at a level at which the lumen of the aorta was partially thrombosed. Also, an effacement of the fat plane between the graft and the adjacent portion of the duodenum was noticed. An upper

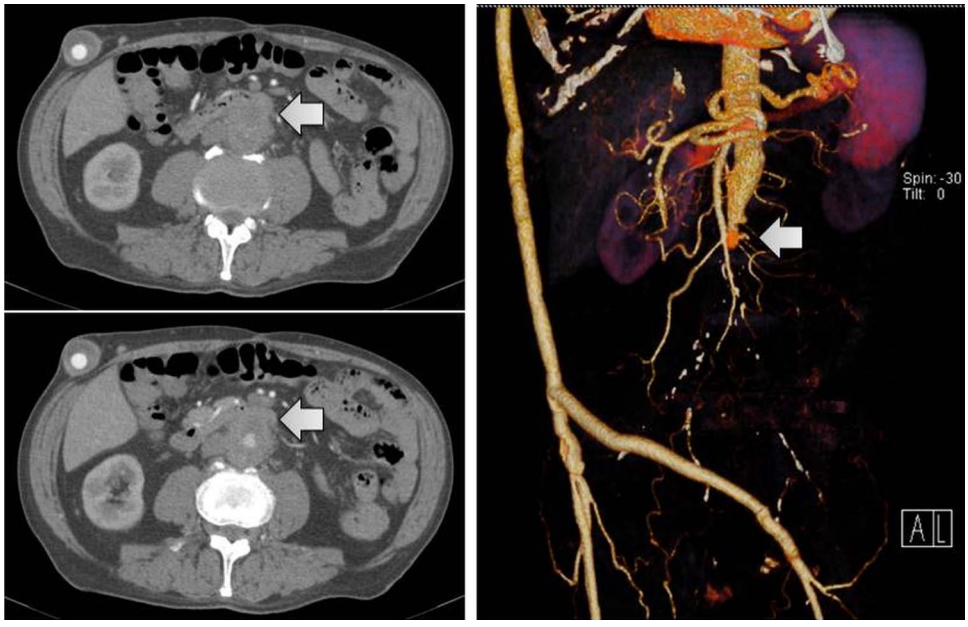

Figure 1 Abdominal CT angiography showing the highly suggestive features of an aortoenteric fistula: proximity between the aortobifemoral bypass graft and the third portion of the duodenum and the effacement of the surrounding fat plane.

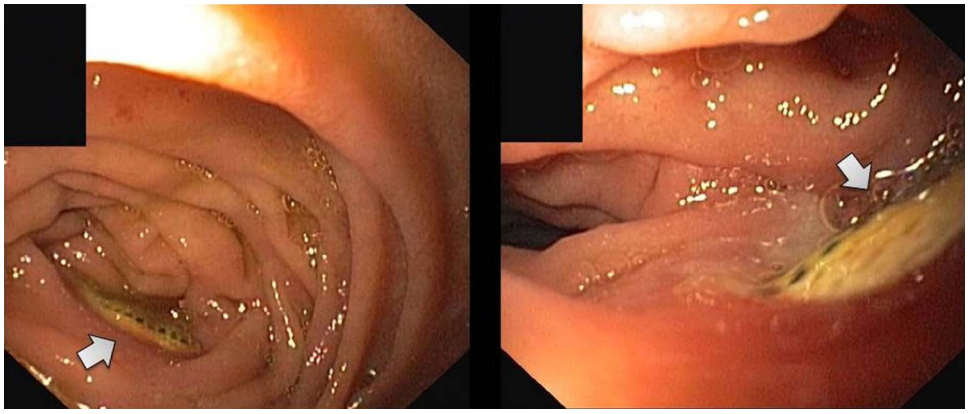

Figure 2 An aortic graft in the third part of the duodenum.

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Learning points

- Aortoenteric fistula is one the most worrisome scenarios in the emergency room and it is associated with high mortality rates (untreated: 100%; after surgical correction or endovascular repair: 50%).[1–3]
- From literature review, the most common clinical presentation is gastrointestinal bleeding, followed by sepsis, secondary to the infection of the graft (generally by gut flora). The classic triad of gastrointestinal bleeding, palpable abdominal mass and abdominal pain is an infrequent clinical presentation. Usually the initial bleeding episode is self-limited (ulceration of the mucosa) and if it is not diagnosed early, a connection between lumens will develop and will be followed by a massive and catastrophic bleeding.[2–3]
- Physicians should have this entity present when evaluating a patient with haematochezia, fever and a history of aortofemoral bypass graft.

endoscopy was performed (figure 2), showing an exposed aortic graft in the third part of the duodenum without stigmata of recent haemorrhage.

The patient was started on broad-spectrum intravenous antibiotics and was promptly evaluated by a vascular and general surgeon. Surgery confirmed the secondary AEF in the third portion of duodenum. The patient was submitted to debridement, graft excision and primary closure of the intestinal loop followed by a gastrojejunostomy. The remaining period of hospitalisation was uneventful.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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