Mycotic Axillary Artery Aneurysm

To the Editor:

A mycotic aneurysm is defined as the limited dilatation of an artery, secondary to an infection of the vascular wall. Spreading of the infection can be intravascular (bacteraemia and septic embolisms especially in infectious endocarditis) or extravascular (contiguous infectious spots, such as abscesses). The relationship between mycotic aneurysms and infectious endocarditis was described for the first time by Osler in 1885 and is a rare complication, especially since it is found in the axillary artery. In the existing literature, only a few isolated documented cases can be found.

We present the case of a 22-year-old woman who was admitted to our institution for a study of periodic fever syndrome. Her history shows a mitral valve prolapse. During the physical examination, a new intense murmur from mitral failure was detected and other peripheral signs consistent with infectious endocarditis (Roth spots, Janeway lesions, Osler’s nodes, embolism in the left upper limb). Laboratory analysis presented leukocytosis (90% neutrophils, of immature form) and increased erythrosedimentation. Haemocultures were 3/3 positive for Staphylococcus aureus non-resistant to methicillin. A transthoracic echocardiogram was also carried out, in which there was evidence of vegetation on the posterior mitral valve. The transoesophageal echocardiogram showed the mitral valve with a myxomatous appearance in which, on the atrial wall of the base of the posterior valve, a multilobed image occupying a large portion of the left atrium was observed. The patient underwent mitral valve replacement with a mechanical prosthesis (the decision was based on the size of vegetation and multiple embolic events), and she completed her antibiotic treatment for infectious endocarditis, progressing without complications. Fifty days after surgical procedure, she presented with peripheral paresthesia-paresis in the left upper limb (predominantly radial, confirmed in the electromyogram); in the clinical exam, a small axillary pulsatile mass was detected. An arterial echo-Doppler was requested, and then an angiography, which showed evidence of a large fusiform aneurysm of the left axillary artery (Figure 1). First, the aneurysm was attempted for repair by inserting an endoprosthesis, but the procedure was not successful. Therefore, conventional surgical treatment was decided, with exeresis of the aneurysm, brachial plexus liberation and axillo-humeral bypass with vein (Figure 2). The patient was discharged 4 days after surgery and after 1 year of follow-up, did not present complications.

Mycotic aetiology was based on the patient’s symptomatic profile, absence of arterial traumatism (including iatrogenic), subsequent anatomopathologic study with degenerative changes and polymorphonuclear leukocytic infiltrate from the intima to the adventitia.

In a bibliographic revision, we found that the physiopathology of mycotic aneurysms includes distal embolism, a pre-existing infection in an arterial lesion, or stent, traumatism of the arterial wall and infection of a contiguous spot. 

Regarding isolated germs, when the aneurysm is associated with infectious endocarditis, we found Staphylococcus aureus and Staphylococcus epidermitis, Streptococcus viridans and Staphylococcus faecalis, Pneumococcus and Haemophilus. Of these, the most frequently isolated is Staphylococcus. 

Other registered germs are Salmonella, Klebsiella, and Escherichia coli. With respect to clinical manifestation, it may vary from asymptomatic—which is detected by pulsatile mass—to serious neurovascular condition due to compression of the brachial plexus or distal embolic events. Spontaneous rupture tends to be a serious complication. 

In the complementary studies, increased leukocytosis and erythrosedimentation are the most important findings. Haemocultures are positive in 50%-70% of patients. Definitive diagnosis of aneurysms can be made through arterial
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We present the case of a 57-year-old woman who 14 months earlier underwent a double aortic and mitral valve replacement with a bileaflet mechanical prosthesis. Discharged after a slow postoperative, she had remained asymptomatic for more than 1 year until recently beginning with dyspnoea and progressive systemic congestion. She did not exhibit fever or infectious symptoms. The thoracic radiography showed a bilateral alveolar interstitial oedema pattern, and the analysis and haemostasis were normal, with INR = 0.99. Interestingly, anticoagulant treatment had been discontinued 4 months earlier due to an episode of mild haemoptysis.

The patient was admitted to the coronary unit, and conventional treatment for heart failure began paired with intravenous heparin sodium. The urgent echocardiography study (Figure) showed absolute lack of opening of one of the mitral prosthesis' leaflets and a reduced opening of the other one, which resulted in a total effective area of 0.8 cm² and an mean gradient of 24 mm Hg. There was thrombotic occupancy on the left appendix and spontaneous echo contrast on the left atrium, although thrombotic material was not observed in the mitral prosthesis. The aortic mechanical prosthesis functioned adequately, and left ventricular systolic function was normal.

Still without locating thrombus in the mitral prosthesis, antecedents of interrupted anticoagulation, the thrombus in the left appendix, and the echo contrast established thrombosis of the prosthesis as the most probable diagnosis. Considering the previously complicated postoperative, initiation of fibrinolytic treatment with rt-PA (10 mg of intravenous bolus followed by another 90 mg in continuous perfusion for 90 min) was chosen. This obtained favourable but insufficient results, with improved opening of the partially immobilized leaflet and persistence of the other leaflet being closed and fixed (effective area, 1.36 cm²; mean gradient, 8.5 mm Hg) (Figure). The patient also improved symptomatically.

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