Mycotic Aneurysms Revisited:
20 Year Experience with Non-Radical Treatment

A Truly Infected Debate!
Drainage of Infected Sac
Drainage of Infected Sac
Drainage of Infected Sac
Drainage of Infected Sac
6.5 cm Pre-Drainage

3 yrs FU

Healed!
Septic, back pain.

<table>
<thead>
<tr>
<th>WBC</th>
<th>CRP</th>
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<tbody>
<tr>
<td>33</td>
<td>260</td>
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Days

Graph showing WBC and CRP over time with values indicating a decrease over days.
Septic, back pain.

WBC
33

CRP
260

PET-CT
5 Months
Septic, back pain.

WBC 33  
CRP 260
Radical surgery may not always be the answer for mycotic aneurysms

MARTIN MALINA
KAROLINA HELCZYNSKA

Patients with aortic infection benefit from a “semi-conservative treatment” with less surgical trauma as compared to radical surgery, Martin Malina and Karolina Helczyńska, Malmö, Sweden, write.

It remains a widely accepted view that aortic infection with a primary mycotic (pseudo-) aneurysm or an infected aortic graft or stent graft should be treated radically. Radical treatment includes resection of the infected blood vessel and subsequent vascular reconstruction—extra-anatomical, or possibly in situ.

Extensive vascular surgery is, however, poorly tolerated by compromised patients such as those with aortic infection. Early morbidity and mortality is significant and late complications include recurrent infection with hematomas. Rise out of the aortic stump, as well as others, identified, and six patients had mixed infections.

The 30-day mortality of SCT was 7%. Overall, infection-related mortality was 34% during a median follow-up of three years.

The most favourable outcome of SCT, with a long-term survival of 83%, was obtained in patients treated for a primary mycotic pseudoaneurysm with stent graft. The least favourable results, with a mortality rate of 30%, occurred in aortoenteric fistulas.

Our most recent patient illustrates the potential advantage of SCT. The 68-year-old was presented...
# Primary Mycotic Aneurysms:

**Nationwide Study of the Treatment of Mycotic Abdominal Aortic Aneurysms Comparing Open and Endovascular Repair.**

<table>
<thead>
<tr>
<th>Mortality</th>
<th>OR</th>
<th>EVAR</th>
</tr>
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<tbody>
<tr>
<td>3 Mo</td>
<td>26%</td>
<td>4%</td>
</tr>
<tr>
<td>12 Mo</td>
<td>27%</td>
<td>16%</td>
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</table>
Infected Stentgrafts

Primary Mycotic Aneurysms
Infected Stentgrafts
Resection of Infected Sac
Resection of Infected Sac

Preop

Post EVAR

24 Mo
Resection of Infected Sac

Preop

Post EVAR

24 Mo
Resection of Infected Sac

Preop  Post EVAR  24 Mo
Resection of Infected Sac

Preop | Post EVAR | 24 Mo
Resection of Infected Sac

Preop  Post EVAR  24 Mo
Resection of Infected Sac

Preop  |  Post EVAR  |  24 Mo
Resection of Infected Sac

Preop  Post EVAR  24 Mo
Resection of Infected Sac

Preop

Post EVAR

24 Mo

Oment Wrap
Resection of Infected Sac

6 Months Post

Oment Wrap
Aortoenteric Fistula
post
Open AAA Repair
Aortoenteric Fistula
post
Open AAA Repair

CRP
165 → 36

October 2018
Postop
6 wks
Aorto-Duodenal Fistula

EVAR + Duodenorrhaphi Sac Resection Omental Wrap
Aorto-Duodenal Fistula
8 Months FU

April 2020

[Medical images and tables with laboratory results]
Infected Aortic Aneurysms

Conclusions

Most Infected Aneurysms Tolerate Poorly Radical Surgery

Most Infected Aneurysms Don’t Need Radical Surgery

Non-Radical Treatment

Less Trauma
Lower Early Mortality
Similar or Better Long Term Survival
Many Infected Aneurysms Heal

Long Term AB Mandatory
St Mark's & Nortwick Park Univ. Hospital