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Mycotic aneurysm: A less known complication of coarctation repair in a child managed by Endovascular aneurysm repair

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Infectious thoracic aortitis and mycotic/infected aneurysm represented two extremes of same disease. If left untreated, an infected nonaneurysmal aorta will likely to progress to mycotic aneurysm. However, mycotic aneurysm usually develops when a preexisting aneurysm becomes infected and usually the site is coarctation of aorta (treated/untreated). Mycotic aneurysm represents 2.6 % of all aortic aneurysms; thoracic aorta is least common site of occurrence. A mycotic aneurysm is occasionally seen in patients with a history of prior cardiac or vascular surgery. Unfortunately, diagnosis of mycotic aneurysm can be challenging and treatment carries significant risks and a high re-infection rate. A 12-year-old child diagnosed with mycotic aneurysm at the site of prior aortic coarctation repair. Initially he was treated as a case of urinary tract infection but on detailed evaluation (echocardiography, CT angiography aorta), diagnosis of aortic artetritis involving site of coarctation repair with mycotic aneurysm was made. There is no role of medical management in mycotic aneurysm. Complete surgical excision of infected aorta in combination with large antibiotic coverage (for at-least 6-12 weeks) is the mainstay of treatment,though very high risk. In selective cases endovascular stenting is being reported in adult patients but none in pediatric. Child was put on IV antibiotics for 6 weeks and once sepsis screen became negative including PET scan, child underwent endovascular aneurysm repair (EVAR) to exclude aneurysm with endurant medtronic limb extension (16-20-93). Child was continued on IV antibiotics for 12 weeks post intervention .Six months post intervention, child is doing fine with no recurrence of infection.

Conclusion: Mycotic aneurysm in children is a rare entity and requires high index of suspicion. Any patient under evaluation for pyrexia of unknown origin, especially with previous history of coarctation intervention, mycotic aneurysm should be ruled out. There is no role of medical management in mycotic aneurysm. Complete surgical excision of infected aorta in combination with large antibiotic coverage (for at-least 6-12 weeks) is the mainstay of treatment. Child underwent EVAR successfully although long-term device durability and infection free survival need to be seen in the child.

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