Abdominal Aortic Aneurysm Associated With Renal Carcinoma

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Citation


Abstract

An 81-year-old male was admitted to the Emergency Service with the complaints of vomiting for 10 days and an intraabdominal mass increasing in size gradually for 6 months. Whole abdominal ultrasound examination was carried out revealing that a hypo-anechoic thrombus formation surrounding the abdominal aorta anteriorly through a segment of 11 centimeters in length. The dimensions of aorta were measured as 71x73 millimeters. At this localization, aorta possessed an open lumen of 31 millimeters in diameter. Moreover, at the inferior pole of the left kidney, a solid mass was found, corresponding to renal carcinoma, that was heterogenous in structure and 13x8 centimeters in diameter. He was hospitalized for further investigation. Whole abdominal CT scan showed an infrarenally located aortic aneurysmal dilation of 8.5x8 centimeters in dimension. Moreover, an intramural thrombus of 6 centimeters in diameter was seen. Craniocaudal extension of the aneurysmal dilation was measured as 7 centimeters. Thoracoabdominal multidetector CT revealed coexisting malignant left renal mass and its lung metastasis (Fig. 1). Simultaneous treatment by EVAR (endovascular aortic repair) and left nephrectomy was planned.

Abdominal aortic aneurysm (AAA) associated with renal carcinoma is rare and this association is about 0.1-3% for kidney neoplasm(1,2,3). In study of Veraldi et al. 913 AAA patients underwent surgical or endovascular repair and in 61 cases (6.7%) an association with a solid neoplasm was found; in 12 cases (1.3%) the neoplasm was a renal cell carcinoma(2). The management of concomitant abdominal aortic aneurysm and intra-abdominal malignancies is still disputed; whether to treat the lesions simultaneously or as staged procedures being the main controversy(1). Combined aneurysm repair and nephrectomy appears to be the treatment of choice in selected patients because simultaneous treatment has the advantage of avoiding a second major abdominal procedure and eliminate the risk of postoperative aortic aneurysm rupture(1,2). The EVAR approach has dramatically modified AAA
treatment, especially for patients with poor general health conditions. When feasible, endografting followed shortly thereafter by nephrectomy should be the treatment of choice especially in high-risk patients as our patient.

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References

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