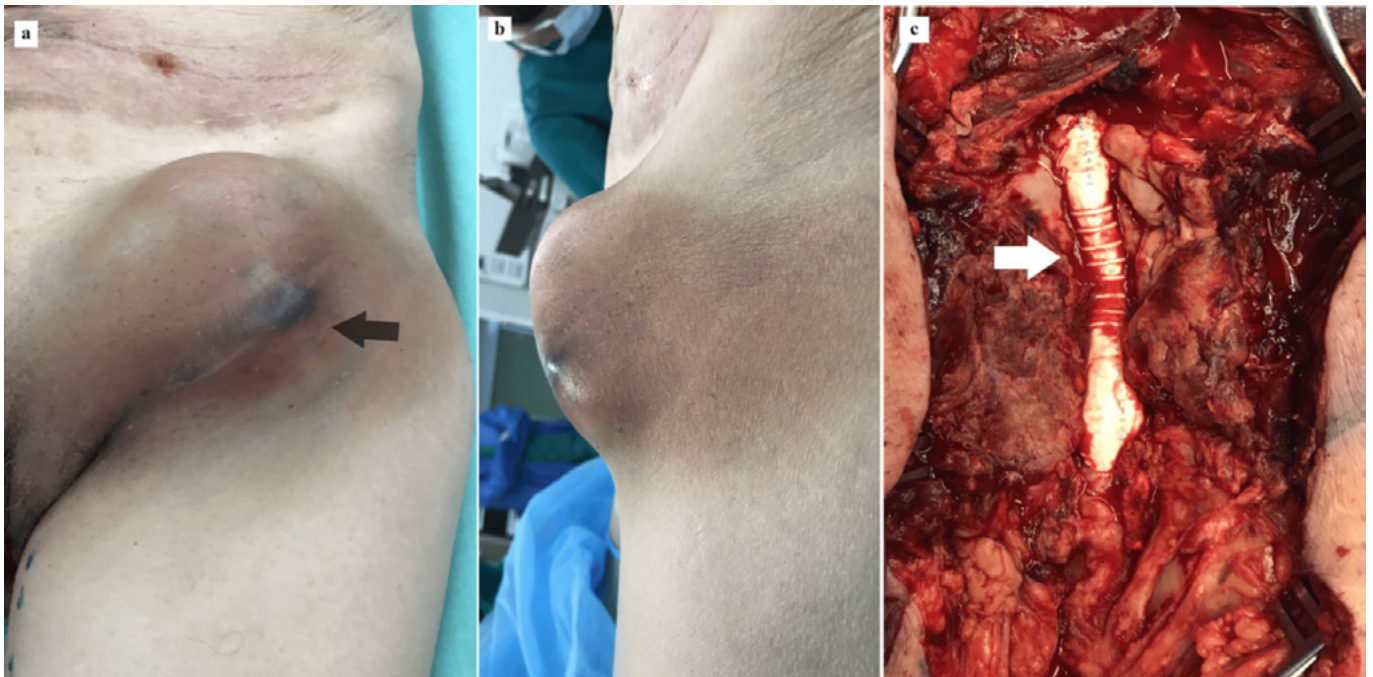


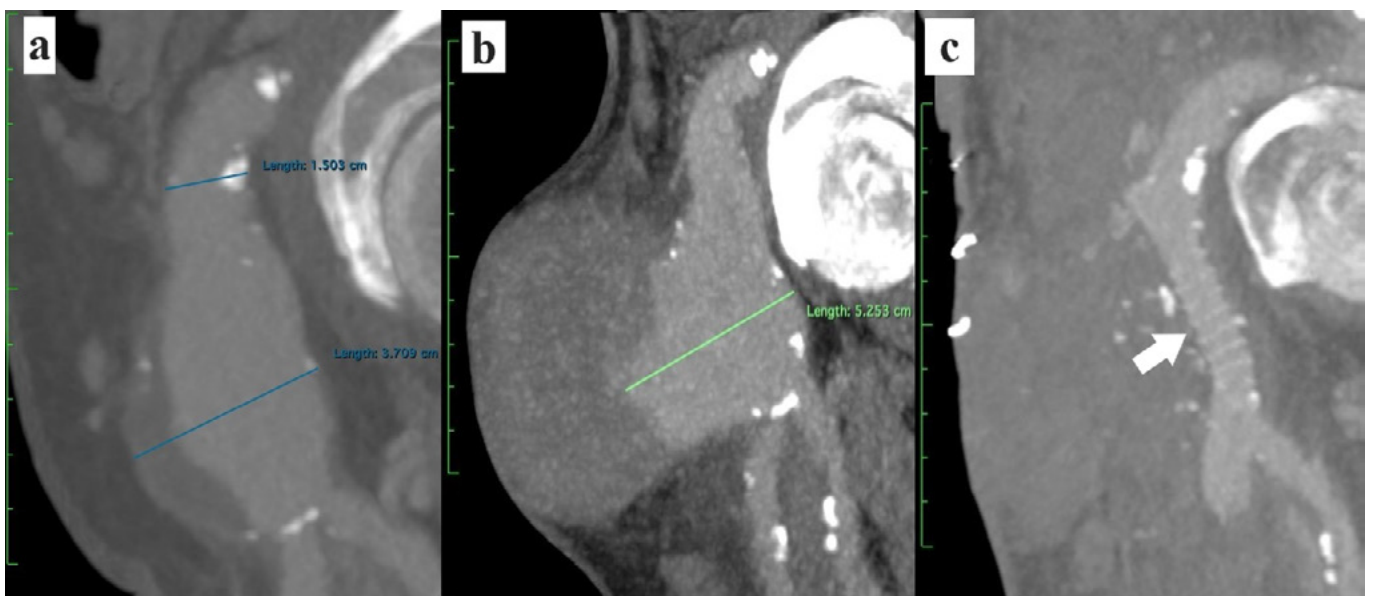
## Ruptured Degenerative Common Femoral Artery Aneurysm

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**Figure 1.** a) Frontal view of the extensive inguinal mass. Spot of imminent skin necrosis is pointed by black arrow. b) Lateral view of the same lesion also helps to appreciate the size and extension of the inguinal mass. c) Intraoperative image of the arterial reconstruction where an 8mm polytetrafluoroethylene (PTFE) graft (white arrow) has been end-to-end anastomosed to the external iliac artery proximally and femoral bifurcation distally.



**Figure 2.** a) Computed Tomography Angiography (CTA) image on a sagittal plane, performed almost a year ago, showing a degenerative left Common Femoral Artery Aneurysm (CFAA) with mural thrombus, measuring 3.7cm. b) CTA image performed at current presentation showing a contained rupture of the ipsilateral CFAA. c) Postoperative CTA image showing the arterial reconstruction. White arrow indicates the 8mm PTFE graft.

A 75-year-old male patient presented acutely complaining of a painful and increased in size left inguinal mass. Being haemodynamically stable, physical examination revealed a severe palpable inguinal mass where the overlying skin was erythematous with spots of imminent necrosis (Figure 1a and b). He had a history of Endovascular aortic Aneurysm Repair (EVAR) eight years ago on the background of aneurysmatic disease progression following an initial open repair of his abdominal aortic aneurysm seventeen years ago. Urgent Computed Tomography Angiography revealed an isolated ruptured Common Femoral Artery Aneurysm (CFAA) (Figure 2b). Right afterwards, under general anaesthesia proximal control was obtained by exposing, through a longitudinal incision, the very distal left External Iliac Artery (EIA) right above the inguinal ligament and distal control by exposing the proximal superficial femoral artery. Following haematoma and aneurysmatic sac evacuation, back-bleeding from the profunda was halted by inflating a 3Fr Fogarty catheter. Then, arterial reconstruction was succeeded by an 8mm polytetrafluoroethylene graft

(Gore Propaten, Flagstaff, AZ, USA) anastomosed proximally to the EIA and distally to the common femoral bifurcation (Figure 1c). Recovery was successful, patient was discharged and returned in three-weeks-time for an endovascular repair of his bilateral type Ib endoleaks. True isolated CFAA is rare with an incidence of five patients per 100,000<sup>1</sup>. Up to 60% of the cases are asymptomatic and recent data suggest that risk of complications like rupture (6%) or thrombosis (4%) are rare for those smaller than 3.5cm<sup>2</sup>. Our patient had a CTA a year ago which showed a left CFA measuring 3.7cm but was not picked up (Figure 2a). Clearly our case shows how aneurysmatic disease progresses with time and sets a high suspicion for an underlying connective tissue disease.

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#### CONFLICT OF INTEREST

None declared.

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