Aortoduodenal fistula: Not always bleeding
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CASE PRESENTATION
A 73-year-old woman presented to a community hospital with three months of intermittent, followed by continuous epigastric pain. There was no gastrointestinal bleeding, nausea, vomiting or fever. A non-contrast abdominal computed tomography scan identified gas locules around an aortobifemoral bypass graft performed in 1992, with surrounding inflammatory fat stranding (Figure 1A). Graft infection was suspected. Metronidazole was prescribed with outpatient follow-up by a vascular surgeon who referred her for gastroscopy. At the third part of the duodenum, a wall defect 3 cm × 2 cm in size was replaced by a yellow-coloured foreign body suspected to be the external surface of an aortic Dacron graft (Figure 1B). The aortoduodenal fistula was treated with an axillofemoral graft, removal of the infected graft and a duodenal-jejunostomy, in which the lateral wall defect at the junction of the third and fourth parts of the duodenum was closed with a loop of proximal jejunum (Figure 1C). Cultures from the excised graft had growth of Candida lusitaniae and Streptococcus constellatus. Antimicrobials were commenced, with recovery in two months.

DISCUSSION
Secondary aortoenteric fistulas, occurring at a rate of 0.3% to 2% and usually three to five years postoperatively, are attributed to arterial pulsations against adjacent duodenum without interposed tissue or chronic low-grade graft infection, usually of intra-abdominal commensal organisms through a biofilm (1-3). Although gastrointestinal bleeding is the most frequent symptom, >60% of patients with fistulas may not exhibit endoscopic signs of bleeding similar to our patient (4). Luminal obstructive symptoms and sepsis from graft infections should also raise suspicions of a fistula, which should be promptly investigated by endoscopy visualizing the third/fourth parts of the duodenum and contrast computed tomography scan showing characteristic findings (3,5). Timely management, either surgically or by endovascular stent placement in high-risk operative patients, is essential for this highly morbid complication (3). There needs to be a low threshold to investigate aortoenteric fistulas by endoscopy.

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REFERENCES