Repair of a Giant Ascending Aortic Pseudoaneurysm Requiring Awake Institution of Cardiopulmonary Bypass

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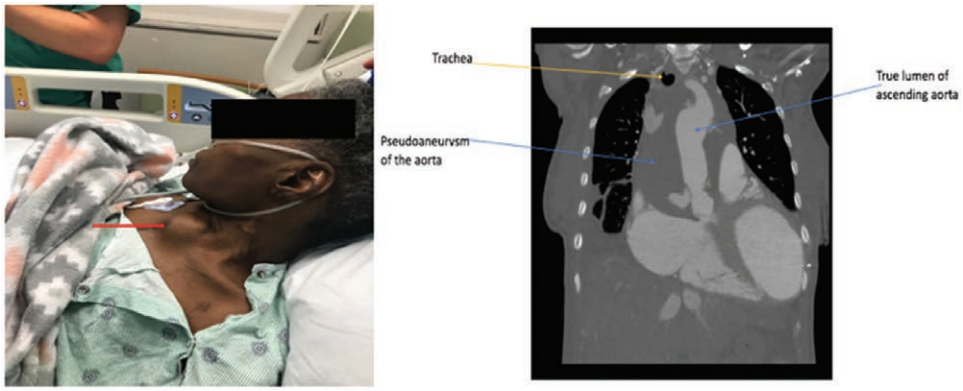

Ascending aortic pseudoaneurysms represent a unique and infrequent complication after type A dissection repair.[1] Massive aortic pseudoaneurysms can present as a large suprasternal pulsating mass with tracheal deviation as shown (*left* and *right panels*). Contrast-enhanced computerized tomography (*right panel*) demonstrates a $10 \times 6.2 \times 13.4$–cm pseudoaneurysm caused by mycotic infection of the aortic graft at the area of anastomosis from a type A dissection repair 3 yr before. Perioperative anesthetic considerations include extrinsic compression of surrounding structures, including the trachea and major vasculature.[2] Airway management of tracheal deviation caused by a pseudoaneurysm may include awake fiberoptic intubation, maintaining spontaneous respiration with an inhalational or intravenous induction, or initiating cardiopulmonary bypass before intubation.[2,3] Tracheal compression from pseudoaneurysms may be managed as above or by either orotracheal intubation distal to the obstruction or high-frequency jet ventilation across the stenosis, but the latter approach risks a fatal hemorrhage because compression of the trachea is caused by the pseudoaneurysm, which can rupture.[3] The pseudoaneurysm deviated the trachea and compressed both mainstem bronchi, as well as the right pulmonary artery (Supplemental Digital Content, http://links.lww.com/ALN/B783). Because of the risk of aneurysm rupture and inability to secure the airway, femoral–femoral cardiopulmonary bypass was instituted while the patient was awake, and then anesthesia was induced and the airway secured.

Competing Interests

The authors declare no competing interests.

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