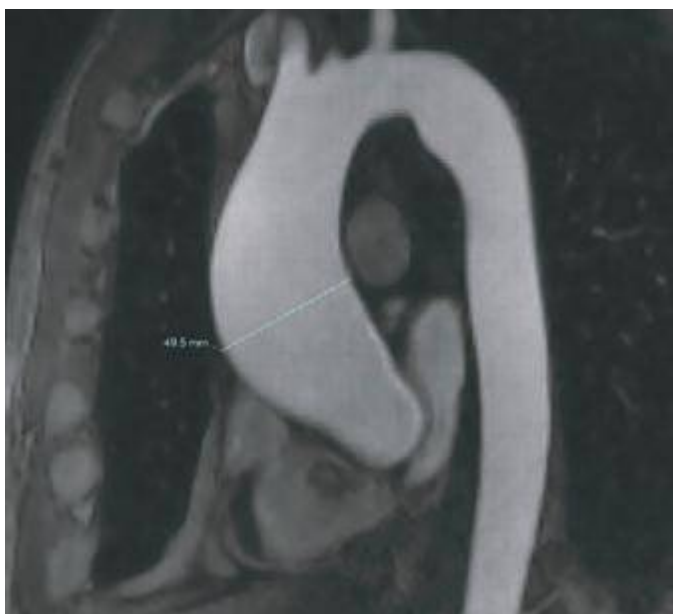




**FIGURE 301-1** A chest x-ray of a patient with a thoracic aortic aneurysm.

of the mediastinal shadow and displacement or compression of the trachea or left main stem bronchus. Echocardiography, particularly transesophageal echocardiography, can be used to assess the proximal ascending aorta and descending thoracic aorta. Contrast-enhanced CT, magnetic resonance imaging (MRI), and conventional invasive aortography are sensitive and specific tests for assessment of aneurysms of the thoracic aorta and involvement of branch vessels (Fig. 301-2). In asymptomatic patients whose aneurysms are too small to justify surgery, noninvasive testing with either contrast-enhanced CT or MRI should be performed at least every 6–12 months to monitor expansion.



**FIGURE 301-2** A magnetic resonance angiogram demonstrating a fusiform aneurysm of the ascending thoracic aorta. (Courtesy of Dr. Michael Steigner, Brigham and Women's Hospital, Boston, MA, with permission.)

$\beta$ -Adrenergic blockers currently are recommended for patients with thoracic aortic aneurysms, particularly those with Marfan's syndrome, who have evidence of aortic root dilatation to reduce the rate of further expansion. Additional medical therapy should be given as necessary to control hypertension. Recent studies indicate that angiotensin receptor antagonists and angiotensin-converting enzyme inhibitors reduce the rate of aortic dilation in patients with Marfan's syndrome by blocking TGF- $\beta$  signaling; clinical outcome trials of this treatment approach are in progress. Operative repair with placement of a prosthetic graft is indicated in patients with symptomatic ascending thoracic aortic aneurysms and for most asymptomatic aneurysms when the ascending aortic diameter is  $>5.5$  cm. In patients with Marfan's syndrome or bicuspid aortic valve, ascending thoracic aortic aneurysms of 4–5 cm should be considered for surgery. Operative repair is indicated for patients with descending thoracic aortic aneurysms when the diameter is  $>6$  cm, and endovascular repair should be considered if feasible when the diameter is  $>5.5$  cm. Repair is also recommended when the diameter of an aneurysm has increased  $>1$  cm per year.

#### ABDOMINAL AORTIC ANEURYSMS

Abdominal aortic aneurysms occur more frequently in males than in females, and the incidence increases with age. Abdominal aortic aneurysms  $\geq 4.0$  cm may affect 1–2% of men older than 50 years. At least 90% of all abdominal aortic aneurysms  $>4.0$  cm are related to atherosclerotic disease, and most of these aneurysms are below the level of the renal arteries. Prognosis is related to both the size of the aneurysm and the severity of coexisting coronary artery and cerebrovascular disease. The risk of rupture increases with the size of the aneurysm: the 5-year risk for aneurysms  $<5$  cm is 1–2%, whereas it is 20–40% for aneurysms  $>5$  cm in diameter. The formation of mural thrombi within aneurysms may predispose to peripheral embolization.

An abdominal aortic aneurysm commonly produces no symptoms. It usually is detected on routine examination as a palpable, pulsatile, expansile, and nontender mass, or it is an incidental finding observed on an abdominal imaging study performed for other reasons. As abdominal aortic aneurysms expand, however, they may become painful. Some patients complain of strong pulsations in the abdomen; others experience pain in the chest, lower back, or scrotum. Aneurysmal pain is usually a harbinger of rupture and represents a medical emergency. More often, acute rupture occurs without any prior warning, and this complication is always life-threatening. Rarely, there is leakage of the aneurysm with severe pain and tenderness. Acute pain and hypotension occur with rupture of the aneurysm, which requires an emergency operation.

Abdominal radiography may demonstrate the calcified outline of the aneurysm; however, about 25% of aneurysms are not calcified and cannot be visualized by x-ray imaging. An abdominal ultrasound can delineate the transverse and longitudinal dimensions of an abdominal aortic aneurysm and may detect mural thrombus. Abdominal ultrasound is useful for serial documentation of aneurysm size and can be used to screen patients at risk for developing an aortic aneurysm. In one large study, ultrasound screening of men age 65–74 years was associated with a risk reduction in aneurysm-related death of 42%. For this reason, screening by ultrasonography is recommended for men age 65–75 years who have ever smoked. In addition, siblings or offspring of persons with abdominal aortic aneurysms, as well as individuals with thoracic aortic or peripheral arterial aneurysms, should be considered for screening for abdominal aortic aneurysms. CT with contrast and MRI are accurate noninvasive tests to determine the location and size of abdominal aortic aneurysms and to plan endovascular or open surgical repair (Fig. 301-3). Contrast aortography may be used for the evaluation of patients with aneurysms, but the procedure carries a small risk of complications such as bleeding, allergic reactions, and atheroembolism. Since the presence of mural thrombi may reduce the luminal size, aortography may underestimate the diameter of an aneurysm.