

CT chest

Extensive calcification and adjacent extra pleural fat thickening along the pleura on postero lateral aspect in right lower pneumothorax, along with mild volume loss in adjoining right middle and lower lobe sequel to old healed infective pleural pathology.

Centrilobular emphysema in bilateral upper lobes and part of apical basal segment of left lower lobe (Figure 1).

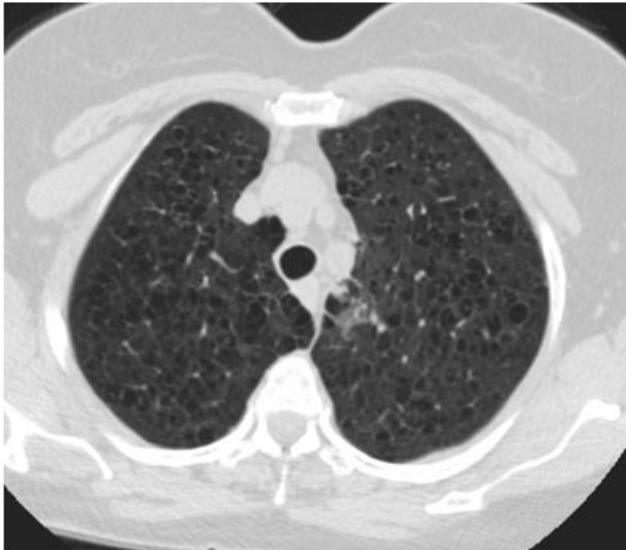


Figure 1: 3D Echocardiogram (echo).

- Hypertensive heart disease.
- Mild concentric left ventricular hypertrophy.
- Good biventricular function LVE F-60%.
- Grade I IV diastolic dysfunction.
- No clot or effusion, no co-relation of aorta.
- No pulmonary hypertension.

Bilateral lower limb arterial Doppler

Findings are highly suggestive of moderate right aortoiliac narrowing and significant narrowing at proximal common femoral artery level suggested CT aorta iliac and lower limb angiograph.

Pre-operative care

Weight monitored was done as per doctors ordered and maintained intake and output strictly. Doctors tried to treat this condition with the help of conservative management i.e. patient admitted in ortho ICU and surgery was planned during hospital stay treatment was going on injection heparin 1000 IU/hr, 2 ml/hr IV, Tab azee 500 MG OD, inj 0.1 mg IV OD, tab folite 5 mg, OD before start surgical operation preparation written consent was taken by patient or patients relative. Patient is NBM for surgery before 6 hour. Physical and psychological preparation was done of patient preoperatively. All these condition were very threatful to patient.

Surgery surgical bypass

The most common minimally invasive treatment is the placement of the stent in your aorta an iliac arteries. This procedure is commonly done at same time as acalcuter directed angiogram. Right iliac artery angioplasty has been planned.

Post-operative care

Post operatively patient shifted in surgery ICU; semi fowler's position was given, 4 hourly Ryle's tube aspiration. Post operatively continuous cardiac monitoring was done, SPO₂ monitored, injection ceftriaxone 200 mg IV BD, injection amikacin 70 mg OD, injection pan 20 mg OD, injection Emset, injection PCM 100 mg IV TDS, Syrup augmentin duo 25 ml BD. On day 2nd patient shifted in ward.

Nursing management

Postoperatively patient was under strict observation of on duty staff. Intravenous fluid administered as per calculated. Observed and record the character of the drainage postoperatively. Care of wound and daily dressing was done. Drainage care was taken and maintains intake and output 2 hourly. Vital signs were recorded strictly. Overall her response was positive for treatment and patient condition too improved progressively. Excellent nursing care was given of patient reported to nursing staff that, patient was very satisfied about nursing care. Complete discharge procedure was explained by nursing staff to the patient family members along with medication prescribed at home as advised by surgeon. The patient was discharged after 14 days without any complications.

Patient visited regularly at OPD for his daily routine checkup, during this period routine checkup was done and he had no any complaints, therefore no furthermore evaluation was found [5].

DISCUSSION

This was a very rare surgical case of osteogenic sarcoma disease, Lalbabu Ojha 67 years male was admitted in MICU presenting with complaint of pain in right lower limb since 1 month. After investigation He was diagnosed aortoiliac occlusive disease. Patient came to casualty on 27/12/2020 at 1.15 pm with chief complaint of right lower limb for which he was admitted in MICU in AVBRH after he under investigation such as CBC, CT chest, 20 ECO etc. COVID-19, virus not identified, clinically epidemiologically diagnosed COVID-19, probable COVID-19, and suspected COVID-19. General examination was done. He was diagnosed as aortoiliac occlusive disease. Although no premedication was administered, parental separation was peaceful. The operation room temperature was maintained at 20 degree celsius. The surgery is peripheral angiography and right iliac artery angioplasty has been planned. Patient admitted in medicine ICU and surgery was planned during hospital stay treatment was going on injection heparin 1000

IU/hr, 2 ml/hr IV, tab azee 500 MG OD, injection 0.1 mg IV OD, tab folite 5 mg OD.

The report is unusual case of acute MI and aortoiliac occlusive disease at the same time as type I. This patient is likely to have a pre-existing severe peripheral arterial disease that has never diagnosed or symptomatic due to his lifestyle. Patient having history of chewing tobacco and obesity has contributed. The factors are responsible for that, percutaneous trans luminal angioplasty was done and that time vascular disease was detected. In STEMI setting aortoiliac occlusion developed because of there are two leading hypothesis, it is responsible for both out patient had pre-existing peripheral arterial disease, during angioplasty to know the demonstrated by difficulty of gaining femoral access. Firstly sudden osteogenic sarcoma because the rupture of pre-existing plaque and secondly the catheter are used that the procedure may have dislodged a thrombus that triggers an immediate aortoiliac occlusion; or catheters that travel through already severely stenosed abdominal aorta may have caused complete obstruction and immediate symptoms distally. In closing, there are two important thoughts that we leave for interventional cardiologists to consider. The first is to be careful when handling the wire and catheter at all times and, even more so, in patients with a history of peripheral vascular disease or risk factors indicating its presence. In this case, the only significant risk factors were obesity, tobacco abuse, sedentary lifestyle and acute STEMI presentation. Although no reported history of claudication and femoral pulse were intact on presentation, distal lower extremity pulse decreased. Decreased distal lower extremity pulses should indicate the presence of pre-existing peripheral vascular disease and alert wire and catheter manipulation. Although it is still unclear what precipitated the aortoiliac occlusion of this patient, it is likely that the actual catheter caused a physical obstruction of the already severely stenosed aorta [6].

CONCLUSION

The report is unusual case of acute MI and aortoiliac occlusive disease at the same time as type I. This patient is likely to have a pre-existing severe peripheral arterial disease that has never diagnosed or symptomatic due to his lifestyle. Patient having history of chewing tobacco and obesity has contributed. These factors are responsible for symptomatic presentation, it can occur during transluminal percutaneous period.

The presence of significant peripheral vascular disease, significant cardiac risk factors and/or difficulty in accessing the femoral artery should be advised by transfemoral approach during percutaneous transluminal angiography. This approach can precipitate aortoiliac occlusion and/or thromboembolism to the lower extremities. We encourage interventional cardiologists to:

- Take extra caution when handling wire and catheter.
- Strongly consider using a transradial.

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ETHICAL APPROVAL

Not applicable.

PATIENT INFORM CONSENT

While preparing case report and for publication patient's informed consent has been taken.

CONFLICT OF INTEREST

The author declares that there are no conflicts of interest.

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