Because of the high risk of massive systemic embolization, it is considered necessary to treat a free-floating thrombus in the aortic arch. However, the ideal treatment remains undefined. Although the use of a thrombolytic is considered one of the options, it carries the risk of selective lysis of the pedicle of the lesion, which would have catastrophic results. In selected patients, surgical treatment is thought to be the most acceptable option[2,4–6].

The purpose of this report was to describe a rare case of floating thrombus in the aortic arch with systemic embolization. In the case reported here, the thrombus was treated successfully through surgery.

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Fistula between the abdominal aorta and a retroaortic left renal vein: a rare complication of abdominal aortic aneurysm

Dear Editor,

A 63-year-old man was referred to our hospital with abdominal pain, left varicocele, hematuria, and acute kidney injury. Multislice computed tomography (CT) revealed a 7.8 cm infrarenal abdominal aortic aneurysm and no contrast enhancement of the left kidney (Figure 1A), as well as a retroaortic left renal vein and dilatation of the left gonadic vein (Figure 1B), together with simultaneous contrast enhancement of the aneurysm, inferior vena cava, and left renal vein, suggesting the presence of a fistula between the abdominal aortic aneurysm and the aberrant left renal vein (Figures 1C and 1D). Given the suitability of the aneurysm, we decided to perform endovascular repair. Exclusion of the aneurysm and the aorto-left renal vein fistula was achieved after successful deployment of a 26–14 × 165 mm bifurcated endoprosthesis with a 16–16 × 95 contralateral limb (Gore Excluder; W.L. Gore and Associates, Flagstaff, AZ, USA). After endovascular management, renal function initially improved. The patient presented intraoperative hypotension, and the postoperative course was complicated by brain ischemia. Unfortunately, the patient died 65 days after surgery due to multiorgan failure.

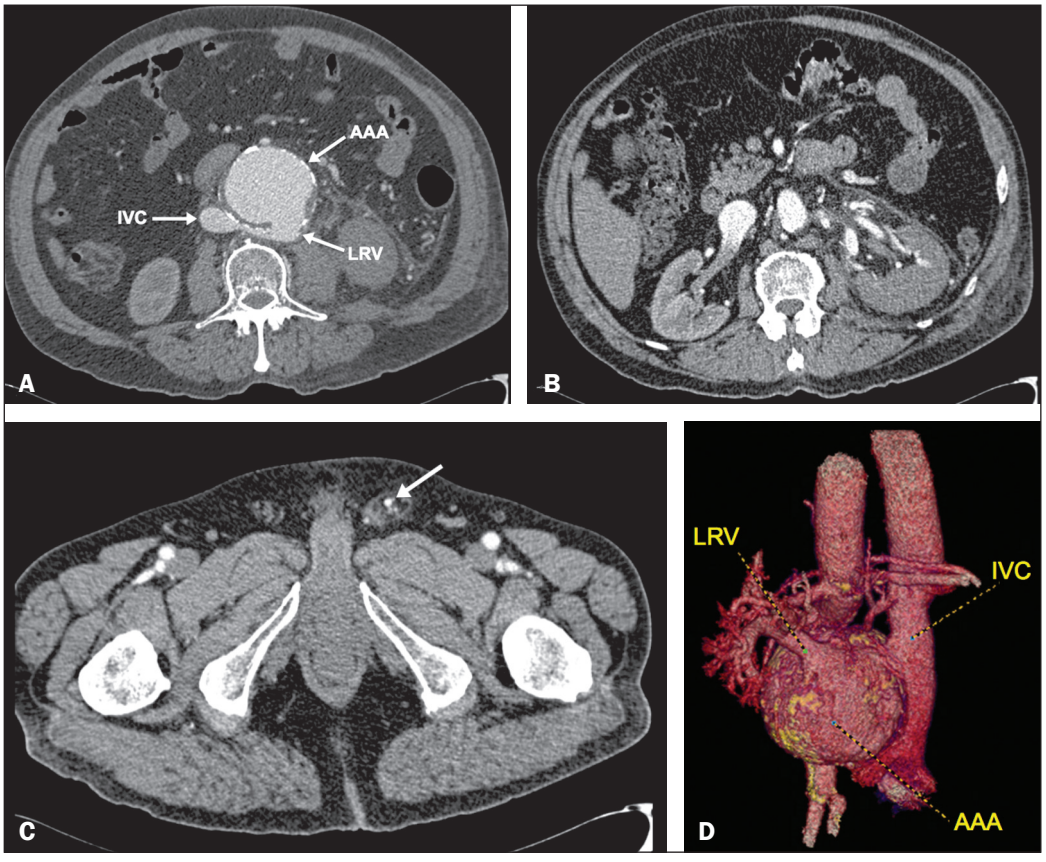

Figure 1. A–C: Contrast-enhanced axial CT slices showing equal opacification of the infrarenal aorta, a retroaortic left renal vein (LRV), and the inferior vena cava (IVC), confirming the fistula between an abdominal aortic aneurism (AAA) and the aberrant left renal vein (**A**). Note the reduced contrast enhancement of the left kidney (**B**) with dilatation and arterial enhancement of the left gonadic vein (arrow, **C**), accompanied by left varicocele. **D:** Contrast-enhanced CT, with three-dimensional reconstruction, in a posterior view, showing the retroaortic left renal vein in communication with the abdominal aortic aneurysm.

Abdominal aortic aneurysm with spontaneous aorto-left renal vein fistula is a rare but well-described clinical entity, usually accompanied by abdominal pain, hematuria, and a nonfunctioning left kidney[1]. In male patients, left varicocele may result from venous overload in the pampiniform plexus via the left gonadal vein[2]. A review of the literature revealed only approximately 30 other reported cases[3–6]. Aorto-left renal vein fistula is often seen in patients with a retroaortic left renal vein, an anatomical variant present in 1.0% to 2.4% of the population[7]. It has been postulated that the vein is compressed between the pulsating aneurysm and the vertebral bodies, leading to erosion of the vessel wall and fistula formation. Open repair is the recognized method of treating rupture of an abdominal aortic aneurysm into a retroaortic left renal vein. Endovascular treatment is an attractive modality because it is minimally invasive, given its capacity for rapid percutaneous arterial access and graft deployment, as well as, if necessary, balloon occlusion for vascular control, thus minimizing blood loss in comparison with open surgery[8]. To our knowledge, this is the sixth reported case in which endovascular repair of this type of fistula has been attempted.

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Pulmonary involvement in Gaucher disease

Dear Editor,

A 33-month-old female patient was referred to the radiology department for evaluation of a two-week history of tachycardia syndrome, presenting without fever or general impairment. She was the daughter of consanguineous parents (first cousins) and had been diagnosed at 7 months of age with Gaucher disease (GD) type 2, on the basis of the evaluation of enzymatic activity. An initial investigation with conventional chest X-ray (Figure 1) revealed a bilateral reticulonodular interstitial pattern. Multidetector computed tomography (MDCT) revealed marked, diffuse thickening of the interlobular and intralobular septa, interspersed with areas of lesser involvement, accompanied by ground-glass opacity of the lung parenchyma, characterizing the crazy-paving pattern (Figure 2).

GD has an autosomal recessive pattern of inheritance and corresponds to glucocerebrosidase deficiency, resulting in the accumulation of glucocerebrosides in macrophages of the reticuloendothelial system; macrophages that have thus been altered are referred to as Gaucher cells[1–3]. That accumulation mainly causes hyperplasia of the liver, spleen, and lymph nodes, hepatosplenomegaly being the principal characteristic of the disease. The lungs, skin, eyes, kidneys, and heart are rarely involved[1–6]. GD is the most prevalent lysosomal storage disease and is traditionally classified into three major phenotypes: type 1 (the chronic, non-neuropathic, adult type), which accounts for 99% of all cases and is characterized by a clinical profile with little clinical evidence; type II (the acute, neuropathic, infantile type), which usually results in death before the age of two years due to pneumonia and anoxia; and type III (the subacute, neuropathic, juvenile type), which has a heterogeneous course. Other less prevalent types are the perinatal-lethal and cardiovascular forms[2–6].

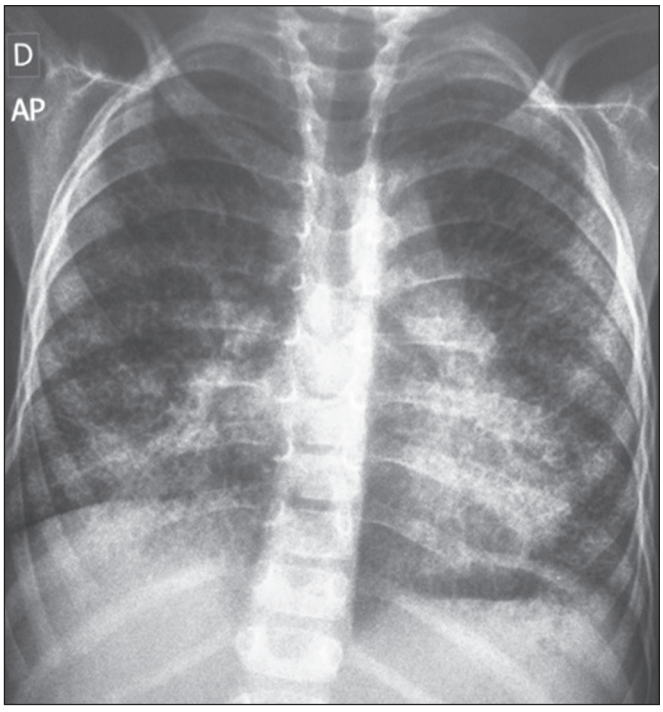

Figure 1. Anteroposterior chest X-ray showing a bilateral reticulonodular interstitial pattern that is more pronounced in the lower lobes.

Although pulmonary involvement is considered rare in GD, it has been frequently identified. However, there have been no epidemiological studies of the issue. In the literature, there is a lack of standardization of the radiological presentations of GD, due to the multifactorial involvement with multiple patterns of tissue infiltration by Gaucher cells[4,6,7].

The imaging characteristics of GD correspond to several pathophysiological mechanisms. In addition to thickening of the