I read with great interest the article entitled ‘Occlusion of the abdominal aorta in a patient with chronic atrial fibrillation’ by Ma et al. [1] that reports a case of intracardiac (left atrial) thrombus with infrarenal occlusion of the abdominal aorta. The legend of Fig. 2 states that the occlusion is of embolic origin. However, the development of such a bypassing collateral vascular network is rather associated with a chronic occlusion. Embolism is an acute event in a patent vessel, manifests as acute aortic occlusion, bypass does not exist, and surgical removal of the emboli is imperative. Acute aortic occlusion (AAO) most commonly results from aortic saddle embolus, in situ thrombosis of a previously atherosclerotic abdominal aorta, sudden thrombosis of small abdominal aortic aneurysms, traumatic elevation of a distal aortic intimal flap, and other rarer etiologies that embolize to the aortic bifurcation. AAO is a different entity than chronic obstruction, where a well-developed collateral circulation may minimize symptoms [2].

The patient probably suffered from aorto-iliac occlusive disease (Leriche syndrome) with significant collateralization [3] and the chronic atrial fibrillation is not associated with the infrarenal aortic occlusion; it simply coexists as concomitant disease and shares common predisposing factors.

REFERENCES

LETTER TO THE EDITOR RESPONSE

Reply to Zisis

Rui-Yan Ma and Ying-Bin Xiao*

Department of Cardiovascular Surgery, Xinqiao Hospital, Third Military Medical University, Chongqing, China

* Corresponding author. Department of Cardiovascular Surgery, Xinqiao Hospital, Third Military Medical University, Chongqing, China. Tel: +86-23-68755607; fax: +86-23-68755607; e-mail: xiaoyb001@sina.com (Y.-B. Xiao).

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We thank Dr Zisis [1] for the comment on our article [2]. We reported a woman with rheumatic heart disease and atrial fibrillation. Computed tomography angiography (CTA) revealed a thrombus in the left atrium, occlusion in the infrarenal aorta and efficient development of collateral circulation of the epigastric arteries. Fig. 2 shows the occlusion suspected to be of embolic