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Prognosis of Aortic Intramural Hematoma With and Without Penetrating Atherosclerotic Ulcer: A Clinical and Radiological Analysis

To the Editor:

We agree with Ganaha et al\(^1\) that differentiation between the distinct clinical entities of intramural hematoma (IMH) and penetrating atherosclerotic ulcer (PAU) is essential. Hemorrhage occurs within the aortic wall during IMH despite a nonatheromatous intact intima, whereas secondary medial hemorrhage occurs through an atheromatous disrupted intima in patients with PAU. Combining data on different diseases processes will hinder accurate documentation of the natural history and definition of management of acute aortic syndromes, in particular the role of thoracic endoluminal stenting.\(^2\)

We disagree with the statement by Ganaha et al\(^1\) that patients with spontaneous IMH of the descending aorta are “typically fairly stable.” It has been reported that branch vessel compromise does not occur with IMH. However, we have described a case of anterior spinal artery compression secondary to descending aortic IMH that resulted in paraplegia.\(^3\) This patient subsequently developed acute ascending dissection. Ide et al\(^4\) have also reported cases of resolution of IMH in the descending aorta followed by the development of prognostically significant aneurysms and also late classical dissection. This late aneurysm development may be explained by a pathological study by Gore,\(^5\) which demonstrated that subadventitial hematoma may be absorbed and organized, changing into a cholesterol-rich amorphous mass that may predispose to the late development of an aneurysm after resolution of IMH.

We recommend surveillance imaging in all patients with IMH, as there is a risk of significant aneurysm formation. This should be continued until at least 6 months after resolution of the hematoma has occurred. Aggressive blood pressure control including \(\beta\)-blockers should be maintained life long.

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