A 47-year-old man presented to his local accident and emergency department with an acutely ischemic left leg. Apart from being a smoker of 30 years, he had no relevant medical or social history. Clinical examination was consistent with femoral embolism with no obvious underlying cause. Examination of the rest of his cardiovascular and respiratory systems was unremarkable. His full blood count, urea, electrolytes, and clotting screen were normal, and ECG showed sinus rhythm with no acute changes.

Intravenous heparin infusion was started, and an urgent embolectomy via a popliteal approach was performed with 4-compartment fasciotomies. On-table completion angiography showed restoration of flow to the foot. The retrieved tissue was sent for histological analysis.

The patient was then transferred to a vascular unit for further investigations. A transesophageal echocardiogram showed a structurally normal heart, but 2 masses were visible in the descending thoracic aorta (Figure 1 and Movie I in the online-only Data Supplement). A computed tomographic angiogram showed a nonenhancing filling defect in the descending thoracic aorta (Figure 2). Magnetic resonance imaging was performed by a specialist cardiovascular imaging unit to further delineate the mass and revealed a transluminal lesion, extending from 60 mm distal to the left subclavian artery to 45 mm above the level of the diaphragm with no surrounding infiltration or other lesions (Figure 3). The appearance suggested an aortic tumor of the descending aorta. Histology of the tissue retrieved at histology was suggestive of myxoma.

Surgical resection of the descending thoracic aorta was performed by a joint cardiac and vascular surgical team via a left lateral thoracotomy with left heart bypass. The supradiaphragmatic descending aorta was isolated and cross-clamped below the tumor. Left atrial to left femoral bypass
was commenced. The aorta was mobilized and clamped proximally just distal to the origin of the left subclavian artery. The involved segment of aorta was excised, and an 18 mm-Dacron interposition graft was sutured in place (Figures 4 through 6). The patient remained stable throughout surgery and made an uneventful postoperative recovery in the intensive care unit. He was transferred to the ward on day 4 and discharged home on day 9.

Histology of the surgical specimen confirmed a high-grade undifferentiated sarcoma of the aorta rather than myxoma (Figure 7). The aortic wall was otherwise normal. The patient had 5 cycles of adjuvant chemotherapy, and remains well and tumor free 18 months after completion of treatment.

Although acute limb ischemia is not uncommon, primary aortic tumor as a source of emboli is rarely seen. The prognosis for most primary aortic tumors is poor, and may be improved by prompt diagnosis and treatment. This case highlights the importance of thorough investigation for an underlying cause in patients presenting with acute lower limb ischemia.

**Disclosures**

None.
Figure 7. Histological specimen of the aortic tumor showing a tunica intima-based tumor composed of atypical round and spindle-shaped cells set within a myxofibrous stroma. The tumor appears to be demarcated by the tunica media, which is not infiltrated by tumor. Left, Magnification ×4; right, ×40.
Aortic Tumor Presenting as Acute Lower Limb Ischemia
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