A 70-year-old man presented with progressively ascending mummification from his bilateral feet to his legs for 1 month. Before this event, he had a severe tearing pain in his chest that radiated to his back and sudden-onset loss of consciousness. At the emergency department, chest computed tomography angiography revealed an aortic dissection with false lumen formation (Figure, A) from the aortic arch to the distal thoracic aorta (Stanford classification type B). Thrombosis with resultant total occlusion from the aortic bifurcation (Figure, B) to the bilateral common femoral arteries was noted. Subsequently, paraplegia with a progressively cyanotic change from both feet to the knees was observed. On physical examination, dry gangrene was found on the lower extremities below the knees without pulsation of dorsalis pedis and posterior tibial arteries (Figure, C). The wound cultures grew methicillin-resistant *Staphylococcus aureus* (MRSA) and *Klebsiella pneumoniae*, and the blood culture also grew methicillin-resistant *S aureus*. He was treated with multiple systemic antibiotics, including ceftazidime, meropenem, vancomycin, and imipenem. Because of his poor general condition after broad-spectrum systemic antibiotics and the high risk of general anesthesia, surgical amputation of both legs was not performed. He died of dry gangrene-related sepsis 1 month later.

**Disclosures**

None.

**Figure.**

A. Aortic dissection in the descending aorta with false lumen (*) was seen. B. Thrombosis with total occlusion in the aortic bifurcation (arrow) and bilateral common iliac arteries was noted. C. There was obvious mummification in both feet and legs.
Dry Gangrene After Aortic Dissection
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