Bacterial infections of the aorta are rare. The label mycotic aneurysm is misleading because mycoses or fungal infections of the aorta are even more rare. The management of bacterial infections of the aorta has always been considered difficult, largely because they frequently herald aortic rupture, and the outcomes of traditional surgery have been poor. Historically, these patients were managed by surgical resection of the aneurysm, debridement of the infected tissue, and revascularization using in situ or extra-anatomic techniques with either prosthetic or, less commonly, autologous grafts. However, the results of such surgery have been disappointing, with many patients being considered unfit to withstand the rigors of such major intervention and, therefore, palliated. Others have died as a result of the attempted curative surgery or had late infectious complications.

The primary consideration in understanding the role of endovascular interventions in bacterial aneurysms is to assess feasibility. Any comparison of outcomes with historical series using standard surgical approaches must be tempered by the progress in antibiotic therapy and intensive care management. The report by Sörelius et al in this issue of Circulation demonstrates the feasibility of the endovascular approach across different centers in Europe, but prospective data will be needed to progress the management of bacterial aneurysms. It is interesting to note that few of these endovascular procedures were used as a bridging procedure to definitive surgery, quite possibly because infections have apparently been arrested or controlled with antimicrobial therapy. An alternative explanation is that some or all of these patients were considered too frail to undergo major surgery, or that possibly, surgeons believe that the results of open surgery are no longer superior to an endovascular approach.

We are assured by the authors that “only a handful” of patients were treated with open repair, but they do not provide numbers or outcomes of those treated with open surgery or no surgery at all. What proportion of patients presenting with bacterial aneurysms to the contributing centers were treated with endovascular interventions? And can we be reassured that those patients treated with antibiotics alone or “palliated” have such terrible outcomes?

The authors acknowledge that there are no standard diagnostic or reporting criteria for the diagnosis of infections of the aorta. Instead, the authors used a panel of 3 criteria (biomarkers) for aortic infection used in everyday clinical practice (judged locally and confirmed in the core laboratory). However, it is quite plausible that some of these patients had alternative diagnoses, such as an inflammatory aneurysm or connective tissue disorders. Additional work will be required to develop consensus guidelines on the diagnosis of bacterial aneurysm (as for infective endocarditis and osteomyelitis of the diabetic foot).

Because this was a retrospective registry, it was not possible to standardize clinical and imaging follow-up. In a prospective registry, it should be possible to strengthen the quality of the data by standardizing diagnosis and follow-up with prespecified criteria and regimens. Specifically, there were no data on the duration of preoperative antibiotics, how patients were followed up, and how missing data (including loss to follow-up) were handled. Were data available for clinical (including microbiological and laboratory testing) and imaging follow-up outcomes? Complications such as endoleak not attributed to infection are not reported. In such cohorts, it is quite possible that there may have been selective loss to follow-up.

Although the overall prognosis associated with endovascular treatment of bacterial aneurysm appeared quite poor, the data are difficult to interpret given the heterogeneous nature of bacterial aneurysms with respect to site within the aorta, the presence of various causative bacteria (and one Candida infection), and the evolution of endovascular technologies.
The presence of gas on a CT scan resulted in a particularly poor long-term survival (5-year survival rate of 36%).

The authors also suggest that patients with a *Salmonella* culture had better outcomes than those without a positive culture or a culture of other bacteria. This requires confirmation in a separate study because it is possible that this observation was attributable to chance alone: the regression analysis with 123 patients used 19 variables, therefore, a much stronger *P* value would be needed to confirm a statistically reliable association.

In summary, these data emanating from the registry on endovascular procedures in aneurysms of bacterial pathogenesis are a useful addition to the literature. However, the registry has several important limitations that hamper clinical interpretation of the data. Additional work is required to elucidate important information with regard to the diagnosis of bacterial aortic aneurysm, the timing of intervention, and to understand which patients may be better managed using an endovascular strategy. It is likely that a well-constructed prospective registry with clearly defined diagnostic criteria and standardized follow-up will be able to answer some of the outstanding questions.

**Disclosures**

None.

**References**


**Key Words:** Editorials ■ aneurysm ■ aorta ■ mycotic aneurysm ■ registries
The Value of Registries for Rare Diseases: Bacterial or Mycotic Aortic Aneurysm
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