Persistent sciatic artery aneurysm: a rare embryological vascular variant

A 64-year-old woman presented with dry gangrene of the right big toe. Right femoral, popliteal and dorsalis arterial pulses were weak. The rest of the physical examination was normal. Peripheral reconstruction using 64-slice multi-detector computed tomography and peripheral angiogram through a catheter via right femoral artery showed that the right internal iliac artery continued as persistent sciatic artery (PSA) and then distally as the popliteal and tibial arteries. The PSA was totally occluded from upper thigh level with fusiform aneurysm with thrombus. Right external iliac artery continued as common femoral artery, and then as profunda femoris and superficial femoral artery, which ends at the level of adductor hiatus (figure 1A–D and see online supplementary movie 1).

PSA is a rare congenital anomaly resulting from lack of regression of embryonic axial artery of the developing lower limb bud. It is a continuation of the internal iliac artery, which communicates with the popliteal and tibial arteries distally. Prevalence of PSA has been estimated to be 0.025%–0.04%. Persistence of this artery can be accompanied by the hypoplastic femoral artery.

Due to its specific anatomic location, PSA is prone to repeated trauma and complications such as aneurysm or distal embolisation. Arterial insufficiency as a result of thrombosis of the aneurysm or distal embolisation of mural thrombus is a common clinical presentation, and it is associated with a high incidence of limb loss.1

K T Sajeer, D Vinayakumar, Babu Kanjirakadavath, M N Krishnan

Department of Cardiology, Government Medical College, Kozhikode, Kerala, India

Correspondence to Dr Sajeer K T, Department of Cardiology, Government Medical College, Kozhikode, Kerala 673008 India; drsajeerkt@gmail.com

Contributors SKT: substantial contributions to conception and design, acquisition of data. VD: Analysis and interpretation of data. BK: Drafting the article or revising it critically for important intellectual content. KMN: final approval of the version to be published.

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/heartasia-2013-010407).


Heart Asia 2013;5:219. doi:10.1136/heartasia-2013-010407

REFERENCES


Figure 1 (A) Multi-detector computerised tomography (MDCT) reconstructed peripheral angiogram: Right internal iliac artery continues as PSA. It is totally occluded at upper thigh (arrow), reforms at mid-thigh level and continues distally as popliteal artery. (B) MDCT reconstructed peripheral angiogram-oblique view showing occluded PSA. Right external iliac artery continues as common femoral artery and divides into profunda femoris and superficial femoral artery. (C) MDCT tissue reconstructed image-coronal view showing total occlusion (arrow) of PSA with distal reformation at mid thigh level and continues distally as popliteal artery. (D) Peripheral angiographic image showing total occlusion (arrow) of PSA with fusiform aneurysm (outline marked). AA, abdominal aorta; CIA, common iliac artery; EIA, external iliac artery; IIA, internal iliac artery; PSA, persistent sciatic artery; PF, profunda femoris; SFA, superficial femoral artery; PA, popliteal artery; ATA, anterior tibial artery; PTA, posterior tibial artery.