Delayed Thoracodorsal Artery Pseudoaneurysm After Thoracoscopic Sympathectomy for Hyperhidrosis in an Adolescent: A Case Report

Adrian KHELIF
ULB: Université Libre de Bruxelles  https://orcid.org/0000-0002-3417-9227

Marc LAUREYS
UVC Brugmann

Karim KHELIF (karim.khelif@huderf.be)
University Children’s Hospital Queen Fabiola  https://orcid.org/0000-0002-0934-1683

Case report

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Abstract

**Background:** Conversely to intercostal artery false aneurysm, thoracodorsal artery pseudoaneurysm after thoracoscopy has never been reported previously.

**Case presentation:** We report the case of a 15-year-old male presenting a delayed thoracodorsal artery pseudoaneurysm after bilateral thoracoscopic sympathectomy. Diagnosis was made by Doppler Ultrasound and confirmed by computed tomography angiography. Angiographic embolization was successfully performed.

**Conclusion:** Thoracodorsal artery pseudoaneurysm should be considered in patients presenting with a parietal thoracic mass following thoracoscopy. This is to the best of our knowledge the first report of thoracodorsal artery pseudoaneurysm after thoracoscopy.

**Background**

Primary focal hyperhidrosis, affects about 1–5% of the population. The axillae, palms and soles are mostly involved. Although benign, it may have social, emotional and professional consequences with marked alteration of quality of life. Thoracoscopic sympathectomy (TS) is mainly offered to patients with severe and debilitating symptoms resisting to conservative management. TS has been widely advocated as a safe and efficient procedure for palmar hyperhidrosis treatment. Herein, we describe the clinical presentation and management of a delayed thoracodorsal artery pseudoaneurysm (TDAP) following bilateral TS in an adolescent.

**Case Report**

A 15-year-old boy with no significant medical past history presented with disabling primary focal palmar hyperhidrosis resisting to conservative treatment. Thorough disclosure of the expected results, side effects and risks related to bilateral TS were given before surgery acceptance.

Surgery was performed with the patient under general anesthesia with a standard endotracheal intubation. The patient was placed in a lateral decubitus position, and a pneumothorax achieved with a Verres needle. A 30° scope was inserted through a 5-mm trocar in the fourth intercostal space in the midaxillary line. The sympathetic trunk, including accessory nerve branches, was divided by a 3-mm diathermy hook at the level of the second, third and fourth ribs. Pneumothorax aspiration under direct vision was followed by trocar removal and drain-free skin closure.

Hemothorax and pneumothorax were ruled out with chest radiographs. The patient was discharged the next day. Hyperhidrosis was significantly improved with an uneventful postoperative course.

Three years later, the patient presented with a painful 3-cm left axillary mass. On clinical examination, the mass appeared mobile and non-pulsatile with normal overlying skin.
Ultrasound (Fig. 1) confirmed a large-neck false aneurysm while Computed Tomography Angiography (CTA) detailed a thoracodorsal artery pseudoaneurysm (Figs. 2 & 3).

The false aneurysm was successfully excluded by means of multiple microcoils embolization, through a right endovascular femoral artery approach (Fig. 4.).

The patient left hospital on day 1. Follow-up after 2 years remains uneventful.

**Figure 1.** Complex thoracic wall pseudoaneurysm on US

**Figure 2 & 3.** Thoracodorsal artery pseudoaneurysm on CTA

**Figure 4.** Digital subtraction angiogram (DSA): TDAP exclusion by means of multiple coils embolization

**Discussion**

TS has proven to be highly efficient in the treatment of palmar hyperhidrosis resisting to conservative treatment. Success rate ranging from 95–98% with lasting good long-term results have been reported\(^3\),\(^4\),\(^5\). Nevertheless, various complications such as pneumothoraces in 7%, hemothoraces in 1%, paresthesia in up to 50% and Horner’s Syndrome in 1% to 2,5% were described\(^3\),\(^4\). Moreover, compensatory hyperhidrosis appears to be the main long-term complication with an incidence of 30 to 85%\(^2\),\(^3\),\(^4\),\(^5\).

It is noteworthy that false aneurysms have never been reported after TS, however.

Only two cases of delayed intercostal artery pseudoaneurysm after thoracoscopy were reported in the English literature. Both cases presented with a large hemothorax after intercostal artery pseudoaneurysm rupture and required surgical attention\(^13\),\(^14\). Conversely to intercostal artery pseudoaneurysm, there are no reports of TDAP after thoracoscopic surgery.

Interestingly, two non-thoracoscopic related cases of TDAP have been previously described. One resulted from fibromuscular dysplasia\(^15\) while the other occurred after latissimus dorsi free flap surgery\(^16\).

Pseudoaneurysms have a variety of causes including inflammation, infection, blunt or penetrating trauma. Surgery can result in pseudoaneurysms through direct vessel injury or the introduction of infection. In our case, we hypothesize that trocar insertion caused arterial wall continuity disruption with constitution of a blood collection between the two outer artery layers, the adventitia and the media, which over time led to symptomatic TDAP development.

In our case, TDAP presented as a painful non-pulsatile axillary lump that could have been easily confused with a variety of other soft tissue masses. Thus, exposing the patient to misdiagnosis and mismanagement.
As an initial diagnostic modality, US picked up a pseudoaneurysm which thoracodorsal origin was detailed by CTA. Definitive diagnosis was made by DSA at the time of treatment.

In recent years, the traditional surgical management of pseudoaneurysm has been widely replaced by endovascular approaches\textsuperscript{17}. Embolization by metallic coils and other materials such as hemostatic particles, glue, thrombin, polyvinyl alcohol have become generalized\textsuperscript{14}. Moreover, US-guided thrombin injection in PA offers an additional interesting minimal invasive option\textsuperscript{17,18}.

**Conclusion**

This case uniquely demonstrates the clinical and radiological features of a delayed pseudoaneurysm after thoracoscopy for sympathectomy. We herein emphasize, not only the delayed clinical presentation and the endovascular treatment of our case but most of all recognition of this unknown entity. This is to the best of our knowledge the first report of a TDPA after endoscopic TS.

**Abbreviations**

CTA: Computed Tomography Angiography; DSA: Digital Subtraction Angiogram; TDAP: Thoracodorsal Artery Pseudoaneurysm; TS: Thoroscopic Sympathectomy; US: Ultrasound

**Declarations**

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**Availability of data and materials**

Please contact author for data requests.

**Authors’ contributions**

AK prepared the first draft of the manuscript and made the literature review. KK made substantial changes in the manuscript, supervised the editing process and contributed to the surgical aspects of the case. LM provided radiology pictures and contributed to manuscript revision. All authors read and approved the final manuscript.

**Ethics approval and consent to participate**

Not applicable.
Consent for publication

Written consent obtained.

Competing interests

The authors declare that they have no competing interests.

Author details

1 Medical Student, Université libre de Bruxelles, Brussels, Belgium.
adrian.khelif@ulb.be

2 Department of Radiology, University Hospital Brugmann, ULB, Brussels, Belgium
marc.laureys@chu-brugmann.be

3 Department of Surgery, University Children's Hospital Queen Fabiola, ULB, Brussels, Belgium.
karim.khelif@huderf.be

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Figures
Figure 1

Complex thoracic wall pseudoaneurysm on US
Figure 2

Thoracodorsal artery pseudoaneurysm on CTA

Figure 3
Thoracodorsal artery pseudoaneurysm on CTA

**Figure 4**

Digital subtraction angiogram (DSA): TDAP exclusion by means of multiple coils embolization

**Supplementary Files**

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