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CASE REPORT CARDIOTHORACIC SURGERY **Open Access**

Successful Management of a Periaortic Graft Abscess After DeBakey Type I Aortic Dissection Repair: A Case Report

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Abstract

Background Periaortic and aortic graft infections (AGI) following thoracic aortic reconstruction are uncommon complications with reported mortality of 25–75% and limited standardised treatment guidance, with debate between graft preservation and complete explantation.

Case presentation A 61-year-old man with type 2 diabetes and obesity (body mass index 41 kg/m²) underwent supracoronary ascending aorta and complete aortic arch replacement for DeBakey type I (Stanford A) acute aortic dissection. Five months postoperatively, recurrent high-grade fever and Pseudomonas aeruginosa bacteraemia developed despite carbapenem therapy. Contrast-enhanced CT demonstrated a progressive perigraft infiltrative collection contiguous with both prosthetic grafts. Redo sternotomy was performed with abscess evacuation and complete replacement of both ascending and arch grafts; intraoperative cultures again grew P. aeruginosa. The patient was discharged on day 30 with culture-directed lifelong ciprofloxacin; follow-up CT confirmed clearance.

Discussion The case fulfilled two MAGIC major criteria (radiologic and microbiologic) and one minor (clinical), confirming AGI. Decisions between graft preservation and complete explantation depend on infection chronology and pathogen virulence; for early-onset deep mediastinal involvement with virulent gram-negative pathogens, complete graft excision combined with prolonged culture-directed antibiotic therapy was the most reliable strategy in this patient.

Conclusion Successful management of periaortic graft abscess after thoracic aortic reconstruction requires high clinical suspicion, MAGIC-criteria-anchored diagnosis, complete graft explantation when infection is established, culture-directed antibiotic therapy, and structured long-term surveillance.

Keywords aortic graft infection; periaortic abscess; aortic dissection; DeBakey type I; Pseudomonas aeruginosa; redo cardiac surgery; mediastinitis; MAGIC criteria

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1. Background

Aortic and periaortic graft infections are rare but potentially fatal complications of aortic reconstructive surgery, with reported incidence of 0.2–5% and mortality between 25% and 75% [1,3,9,10]. Prosthetic graft infection involving the thoracic aorta presents particular technical and microbiological challenges because the proximity of the prosthesis to mediastinal structures creates a deep and confined operative field, and because management of established infection often requires reoperation in patients who are already physiologically compromised by the index procedure [11,12,13,14].

Although the European Society for Vascular Surgery (ESVS) 2020 guidelines and the Management of Aortic Graft Infection Collaboration (MAGIC) case definition provide a clinical framework for diagnosis and management, no universally accepted protocol defines the optimal balance between graft preservation and complete explantation [1,3,4,11]. Decisions are typically individualised on the basis of infection chronology, pathogen virulence, anatomical extent, and patient physiology.

We report the case of a 61-year-old man who developed a periaortic graft abscess and prosthetic graft infection five months after supracoronary ascending aorta and complete aortic arch replacement for DeBakey type I (Stanford A) acute aortic dissection. The infection was successfully managed by redo sternotomy with abscess evacuation and complete re-replacement of both the ascending aorta and aortic arch prostheses, combined with culture-directed lifelong antibiotic therapy. The case is reported in accordance with the CARE (CAse REport) guidelines for case-report transparency [6].

2. Case presentation

2.1 Initial admission and index operation

A 61-year-old man with a history of type 2 diabetes mellitus and obesity (body mass index 41 kg/m²) was transferred to our institution intubated from a referring hospital with a working diagnosis of acute aortic dissection and cardiac tamponade. Intraoperative findings confirmed a DeBakey type I (Stanford A) dissection involving the ascending aorta and aortic arch.

The patient underwent supracoronary ascending aorta resection with vascular prosthesis reconstruction, and complete aortic arch resection with reconstruction using a custom tetra-branch graft fashioned from a pre-fabricated aortobifemoral prosthesis (Figure 1B). The procedure was completed without intraoperative complications. Cardiopulmonary bypass (CPB) time was 190 minutes and aortic cross-clamp time 78 minutes.

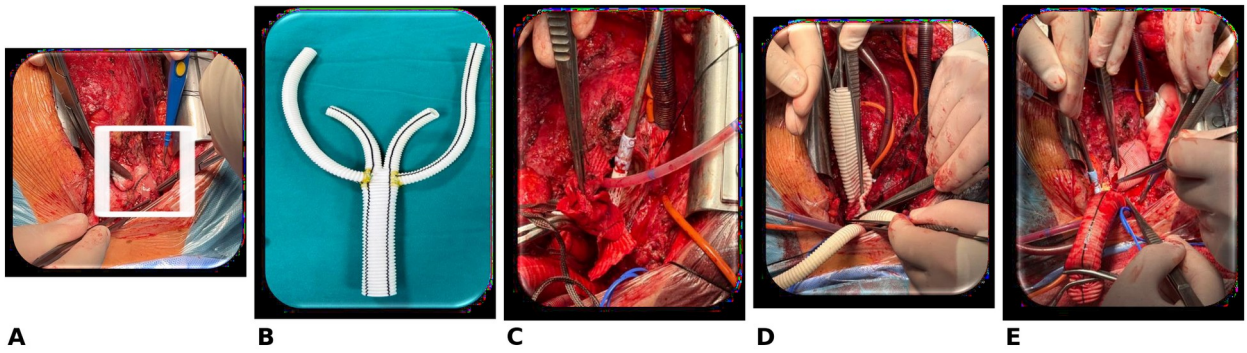

Figure 1. Intraoperative findings and surgical reconstruction. (A) Localised collection of thick yellowish fluid surrounding the ascending aorta and aortic arch anastomoses, involving both prostheses, consistent with mediastinitis. (B) Pre-fabricated aortobifemoral prosthesis modified into a custom tetra-branch graft for aortic arch reconstruction at the index procedure. (C–E) Intraoperative views of redo sternotomy, exposure of the infected prostheses, and complete re-replacement of the ascending aorta and aortic arch with new vascular grafts.

The early postoperative course was uneventful and the patient was discharged on postoperative day 25 under outpatient follow-up by infectious disease and cardiology services. Preoperative urine cultures had identified Pseudomonas aeruginosa for which targeted antibiotic therapy was continued in line with susceptibility testing.

2.2 Postoperative course and recurrent infection

During follow-up the patient experienced intermittent low-grade fevers, managed with carbapenem therapy under infectious disease guidance, and a concurrent diagnosis of brucellosis was made and treated. A surveillance contrast-enhanced computed tomography (CT) of the chest demonstrated a localised infiltrative area adjacent to the ascending aorta and aortic arch anastomoses, contiguous with the prosthetic graft (Figure 2).

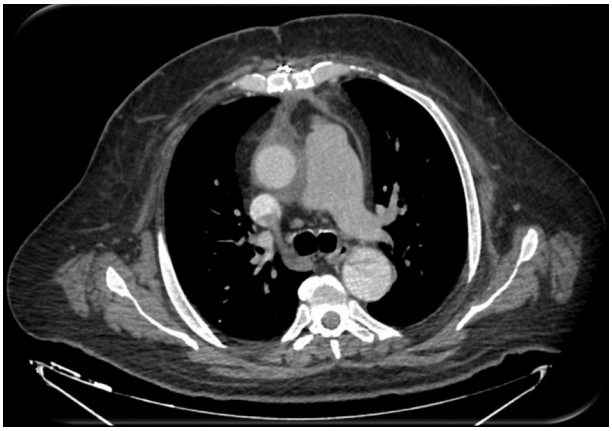

Figure 2. Pre-operative contrast-enhanced chest computed tomography demonstrating the perigraft infiltrative collection adjacent to the ascending aorta and aortic arch anastomoses, contiguous with the prosthetic graft.

Five months after the index operation the patient presented with recurrent high-grade fever despite ongoing antibiotic therapy. Repeat chest CT demonstrated progressive perigraft infiltrate. Inflammatory markers were elevated and urine cultures again grew P. aeruginosa. The combined clinical, microbiological, and radiologic findings fulfilled two MAGIC major criteria (radiologic and microbiologic) and one minor (clinical) criterion, confirming aortic graft infection (Table 1) [3,4]. After multidisciplinary review, surgical intervention was planned.

2.3 Reoperation

The patient underwent redo sternotomy. Intraoperatively a localised collection of thick, yellowish fluid was identified surrounding the ascending aorta and aortic arch anastomoses, involving both prostheses, consistent with mediastinitis (Figure 1A). The aortic prostheses appeared yellowish with early signs of fistulisation and partial structural degradation.

The infected tissue was completely evacuated and excised. Because both grafts were involved and because homograft and xenopericardial alternatives were not available locally, complete replacement of both the ascending aorta and aortic arch was performed with new vascular prostheses (Figure 1C–E). The procedure was completed uneventfully with CPB time of 225 minutes and cross-clamp time of 80 minutes. The operative field was irrigated sequentially with alcohol, saline, vancomycin, and gentamicin. Multiple intraoperative cultures again grew P. aeruginosa.

2.4 Postoperative recovery and follow-up

Postoperatively, intravenous antibiotics were continued. The patient's clinical and laboratory parameters improved, with resolution of febrile episodes. Follow-up chest CT confirmed complete clearance of the previous perigraft infiltrate. The patient was discharged on postoperative day 30 with culture-directed lifelong oral ciprofloxacin and structured outpatient surveillance under combined cardiac surgery and infectious disease teams.

3. Discussion

3.1 Epidemiology and clinical importance

Periaortic graft infections complicate approximately 0.2–5% of aortic reconstructive procedures and carry mortality of 25–75% even with appropriate intervention [1,9,10,15]. Risk factors are not fully characterised, but immunosuppressed states (including diabetes mellitus and obesity, both present in our patient), prolonged operative time, postoperative bacteraemia, and emergency surgery for acute dissection are recognised contributors [1,2,17]. The rarity of these infections and the heterogeneity of presenting features result in delayed recognition in many cases.

3.2 Classification by chronology and microbiology

Postoperative aortic graft infections are classified as early-onset (presentation within four months of the index procedure) or late-onset (presentation beyond four months) [1,7,8]. Early-onset infections are typically related to direct intraoperative bacterial inoculation, most commonly with Staphylococcus aureus, and present with an acute, toxic clinical course. Late-onset infections are more often associated with immunosuppression, nosocomial bacteraemia, postoperative leakage, or prosthesis

thrombosis, and are typically caused by less virulent organisms (coagulase-negative Staphylococcus, Corynebacterium, Cutibacterium acnes), producing a more indolent course [16,17].

In the present case, infection became clinically manifest five months postoperatively, but radiologic features were already present at earlier surveillance, suggesting an early-onset infection that progressed through the late-onset window before being conclusively recognised — a chronology compatible with low-virulence persistence followed by progressive Pseudomonas seeding from a urinary source. Identification of the causative organism is essential because culture-directed antibiotic therapy is a cornerstone of management [1,3].

3.3 Diagnostic framework

Clinical features of aortic graft infection are nonspecific and include fever, fatigue, weight loss, back or chest pain, and laboratory evidence of systemic inflammation [2,3,5]. High clinical suspicion is therefore essential. ^{18}F-fluorodeoxyglucose positron emission tomography combined with CT (^{18}F-FDG PET/CT) is considered the most sensitive diagnostic modality where available; in its absence, contrast-enhanced CT remains the principal imaging tool [5]. Suggestive findings include persistent or progressive perigraft fluid; ectopic gas within or around the graft; increased perigraft soft-tissue volume with loss of normal architecture; and pseudoaneurysm formation [3,5].

Transthoracic and transoesophageal echocardiography may complement CT for the thoracic aorta. The 2016 MAGIC criteria from the Management of Aortic Graft Infection Collaboration provide a structured diagnostic framework based on clinical, radiologic, and microbiologic findings, each categorised into major and minor descriptors [3]. Aortic graft infection is suspected when one major criterion or two minor criteria from different categories are present and is confirmed when a major criterion is supplemented by another criterion from a different category. Subsequent prospective validation in the VASGRA cohort demonstrated good diagnostic accuracy [4]. Our case fulfilled two major criteria (radiologic and microbiologic) and one minor (clinical), establishing a definite diagnosis (Table 1).

Table 1. Application of the MAGIC criteria to the present case [3,4].

Criterion (category, level)	Finding in the present case	Met
Clinical / surgical (minor)	Recurrent high-grade fever and systemic inflammation despite carbapenem therapy.	Yes
Radiologic (major)	Progressive perigraft infiltrative collection on serial contrast-enhanced CT, contiguous with both ascending and arch prostheses.	Yes
Microbiologic (major)	Pseudomonas aeruginosa isolated from peripheral cultures and from multiple intraoperative graft-site cultures at re-exploration.	Yes
Final diagnosis	Two major criteria (radiologic + microbiologic) plus one minor (clinical) — definite aortic graft infection.	Confirmed

MAGIC, Management of Aortic Graft Infection Collaboration; CT, computed tomography.

3.4 Surgical management: preservation versus explantation

Treatment consensus is limited and multiple management algorithms exist [1,10,11,18,19]. The Samson classification, originally derived for peripheral arterial graft infection and subsequently extended to aortic grafts, stratifies infections by anatomical depth and informs the choice between preservation and explantation [7]. In broad terms, early-onset superficial infections without anastomotic involvement may be amenable to graft preservation with debridement, drainage, and prolonged culture-directed antibiotics [10,16]; early-onset infections involving the graft body but without overt anastomotic disruption can sometimes be managed with in-situ replacement using rifampin-bonded grafts, homografts, or xenopericardial conduits [12,13]; and established deep infections with anastomotic involvement, fistulisation, or virulent organisms typically require complete graft explantation and reconstruction [1,10,11].

Empirical broad-spectrum antibiotic therapy should be initiated upon suspicion and refined when culture results are available [1,2,17]. The optimal duration is undefined; most authorities recommend 4–6 weeks of intravenous therapy followed by oral suppression for 6 months, while lifelong suppressive therapy is increasingly advocated for retained prosthetic

material or anatomically inaccessible infection [1,2,16].

In the present patient, deep mediastinal involvement of both ascending and arch prostheses by P. aeruginosa, with intraoperative evidence of early fistulisation, made graft preservation untenable; complete explantation with replacement was selected and combined with prolonged culture-directed therapy and lifelong oral ciprofloxacin suppression.

3.5 Lessons from this case

Several practical lessons emerge for similar cases. Persistent low-grade fever in the early postoperative period after thoracic aortic reconstruction warrants early CT, even when an alternative source has been identified, because aortic graft infection may evolve insidiously alongside other infections. A urinary or remote source of Pseudomonas bacteraemia in a patient with a recent thoracic aortic prosthesis should prompt active surveillance for graft seeding. Where ^{18}F-FDG PET/CT is unavailable, serial contrast CT remains the most pragmatic diagnostic strategy and can demonstrate progression of infiltrative perigraft changes that confirm infection [5]. Decision-making between preservation and explantation should be multidisciplinary, anchored in MAGIC criteria, and individualised on the basis of pathogen virulence, anatomical extent, and patient physiology [3,4]. Lifelong oral antibiotic suppression is appropriate where retained or replaced prosthetic material remains in a contaminated mediastinal field [1,2].

3.6 Limitations

This is a single-patient case report and conclusions cannot be generalised. ^{18}F-FDG PET/CT was not available at the local institution, which may have delayed diagnostic confirmation. Long-term durability of the second graft and durability of antibiotic suppression require continued follow-up.

4. Conclusion

Aortic and periaortic graft infections are severe complications of thoracic aortic reconstructive surgery whose management remains individualised. In this patient, complete explantation and replacement of both ascending and arch prostheses, combined with culture-directed prolonged and lifelong oral antibiotic therapy, achieved a favourable outcome. Early recognition through structured application of the MAGIC criteria, surveillance imaging, and microbiological vigilance is essential. The case adds to the limited literature on extensive prosthetic re-replacement for periaortic graft infection following acute aortic dissection repair and reinforces the role of multidisciplinary governance in optimising outcomes.

Abbreviations

AGI — Aortic graft infection

BMI — Body mass index

CARE — CAse REport guidelines

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CPB — Cardiopulmonary bypass

CT — Computed tomography

DOI — Digital Object Identifier

ESVS — European Society for Vascular Surgery

^{18}F-FDG PET/CT — ^{18}F-fluorodeoxyglucose positron emission tomography / computed tomography

GMJ — Georgian Medical Journal

ICMJE — International Committee of Medical Journal Editors

MAGIC — Management of Aortic Graft Infection Collaboration

MD — Doctor of Medicine

ORCID — Open Researcher and Contributor ID

PHIG — Public Health Institute of Georgia

VASGRA — Vascular Graft Cohort Study

VGEI — Vascular graft / endograft infection

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Authors' contributions

GG: Conceptualization; methodology; surgical management; investigation; writing — original draft; writing — review and editing; supervision; final approval.

BN: Surgical management; investigation; writing — review and editing; final approval.

MK: Investigation; perioperative critical care; data curation; writing — review and editing; final approval.

GeG: Investigation; perioperative critical care; data curation; writing — review and editing; final approval.

MM: Investigation; cardiology assessment; data curation; writing — review and editing; final approval.

All authors read and approved the final manuscript.

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Declarations

Ethics approval and consent to participate Not applicable. The study describes the de-identified clinical course of a single patient and did not involve research interventions or individual-level data beyond that required for the patient's clinical care; institutional ethics-committee approval was therefore not required. Written informed consent for publication was obtained from the patient (see Consent for publication).

Consent for publication Written informed consent was obtained from the patient for publication of this case report and all accompanying clinical and intraoperative images. A copy of the consent form is available for review by the Editor-in-Chief on request.

Conflict of interest disclosures The authors declare that they have no competing interests, financial or non-financial, related to the subject matter of this article.

Data sharing All clinical data underlying this case report are summarised within the manuscript. Further de-identified data are available from the corresponding author on reasonable request, subject to applicable data-protection legislation. The article is preserved under its DOI (10.66636/gmj.v1.i2.a118) via the journal's preservation infrastructure (Zenodo, PKP PN, LOCKSS, DataCite).

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