

PURPOSE

Aortic graft infections carry significant morbidity and mortality risk. Indolent prosthetic graft infections can be particularly challenging to diagnose as symptoms may be subtle and the patient may have negative diagnostic studies. We discuss diagnosis and management of delayed aortobifemoral graft infection with chronic groin wounds to highlight the diagnostic challenges in patients with indolent graft infections and to describe definitive surgical management.

MATERIALS/METHODS

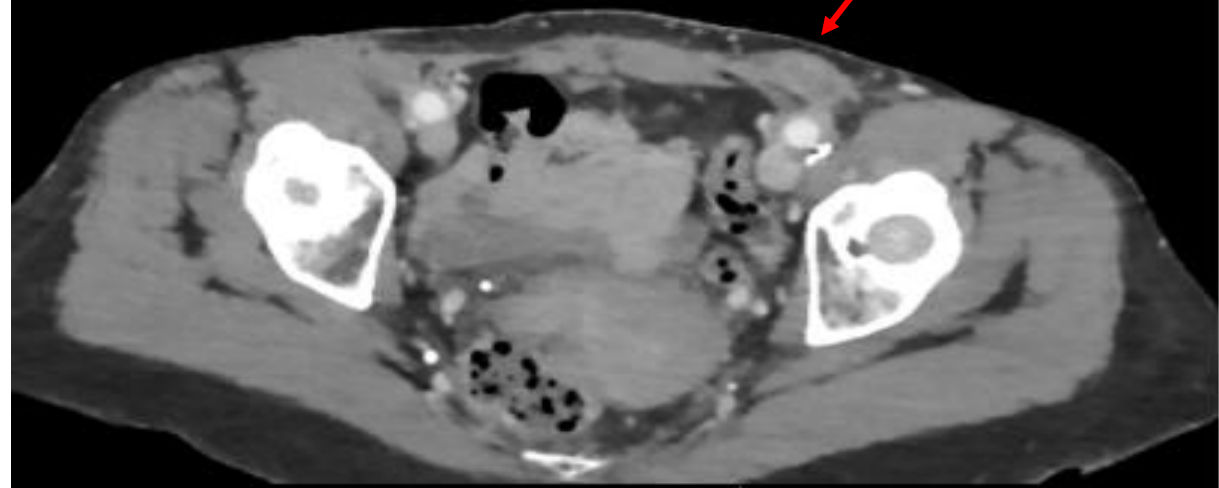
55 y/o F with past medical history of aortobifemoral bypass performed at an outside hospital was referred for a pinpoint wound in the right groin with drainage. CT angiogram was obtained and demonstrated a small amount of fluid along the distal aortic graft, mild fat stranding along the groin near the distal right femoral graft limb, and a small fluid collection in the left groin. Blood cultures and tagged WBC scan were negative for infection. Pt underwent a right groin exploration with sharp excisional debridement of sinus tract to healthy tissue with concomitant advancement flap by plastic surgery. Persistent right groin drainage on follow-up prompted repeat imaging which noted persistence of fluid surrounding the graft. Repeat operative exploration revealed a sinus tract extending to the prior aortobifemoral graft with milky drainage, and intraoperative cultures grew *Prevotella* and *Finegoldia* species. The patient was offered explantation of the existing graft with in-situ reconstruction. The patient underwent explantation of prior aortobifemoral bypass graft, bilateral femoral endarterectomies with patch angioplasties and redo aortobifemoral bypass with rifampin-soaked gel weave Dacron graft. Meropenem impregnated antibiotic beads were placed during reconstruction.

IMAGING

11/19/2025



8/26/2025



3/11/2026



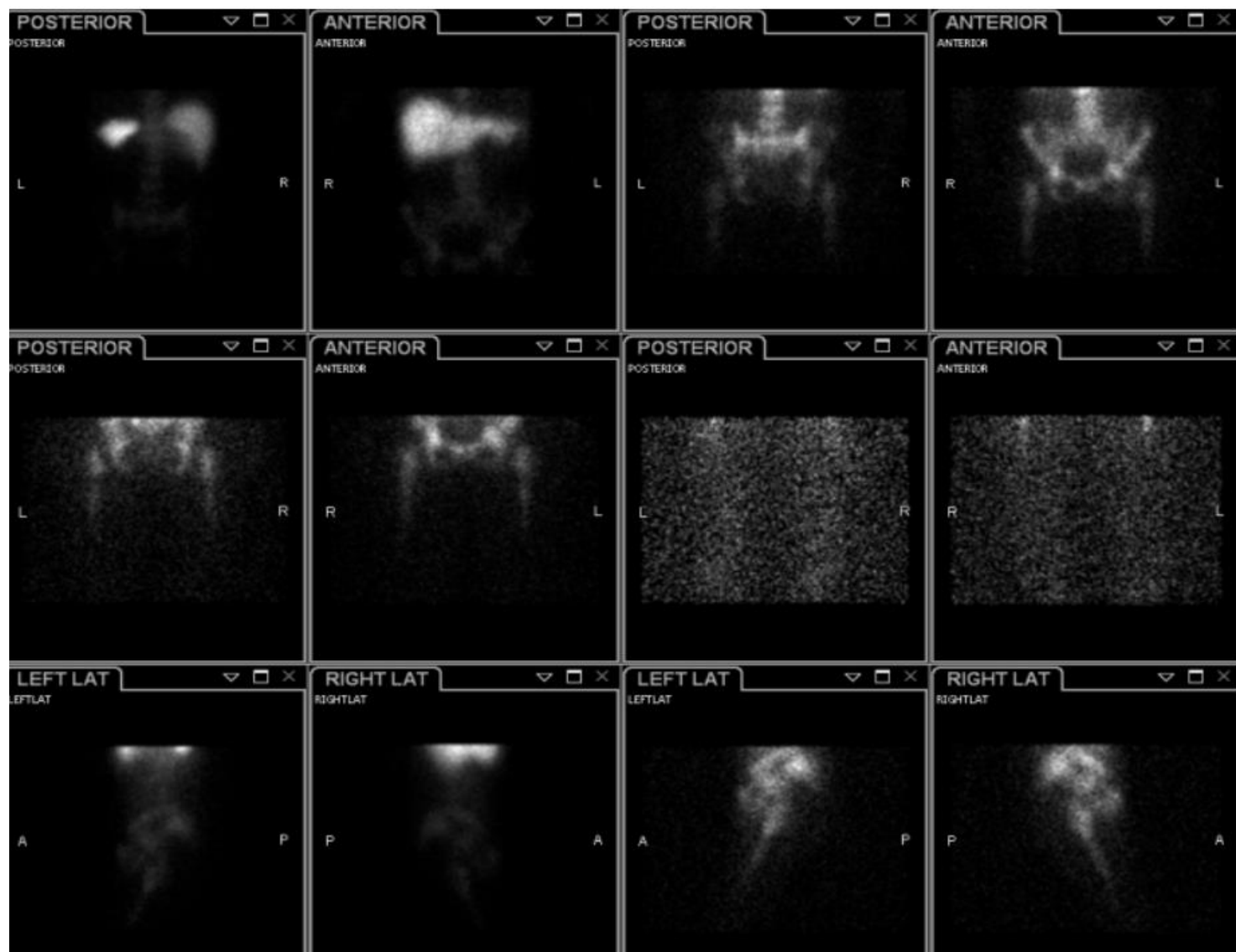
3/11/26: Moderate amount of fluid surrounding the graft

RESULTS

Intraoperatively, purulent material was found to be surrounding the graft within the bilateral groins and the abdominal aorta itself. Final cultures obtained during graft explantation demonstrated no microbial growth. The postoperative course was uncomplicated without evidence of persistent infection. The patient was discharged home on postoperative day 8 on lifelong antibiotic suppression with Augmentin

CONCLUSION

This case highlights the diagnostic complexity of indolent aortic graft infections that may persist despite multiple intervention attempts and negative imaging findings. Chronic groin drainage and persistent peri-graft fluid should raise suspicion for ongoing prosthetic graft infection. Early recognition and definitive surgical management remain critical to achieving source control with clinically favorable outcomes.



8/29/25 No abnormal focus of uptake to suggest infection/inflammation