

False aneurysm of the subclavian artery with chest wall destruction

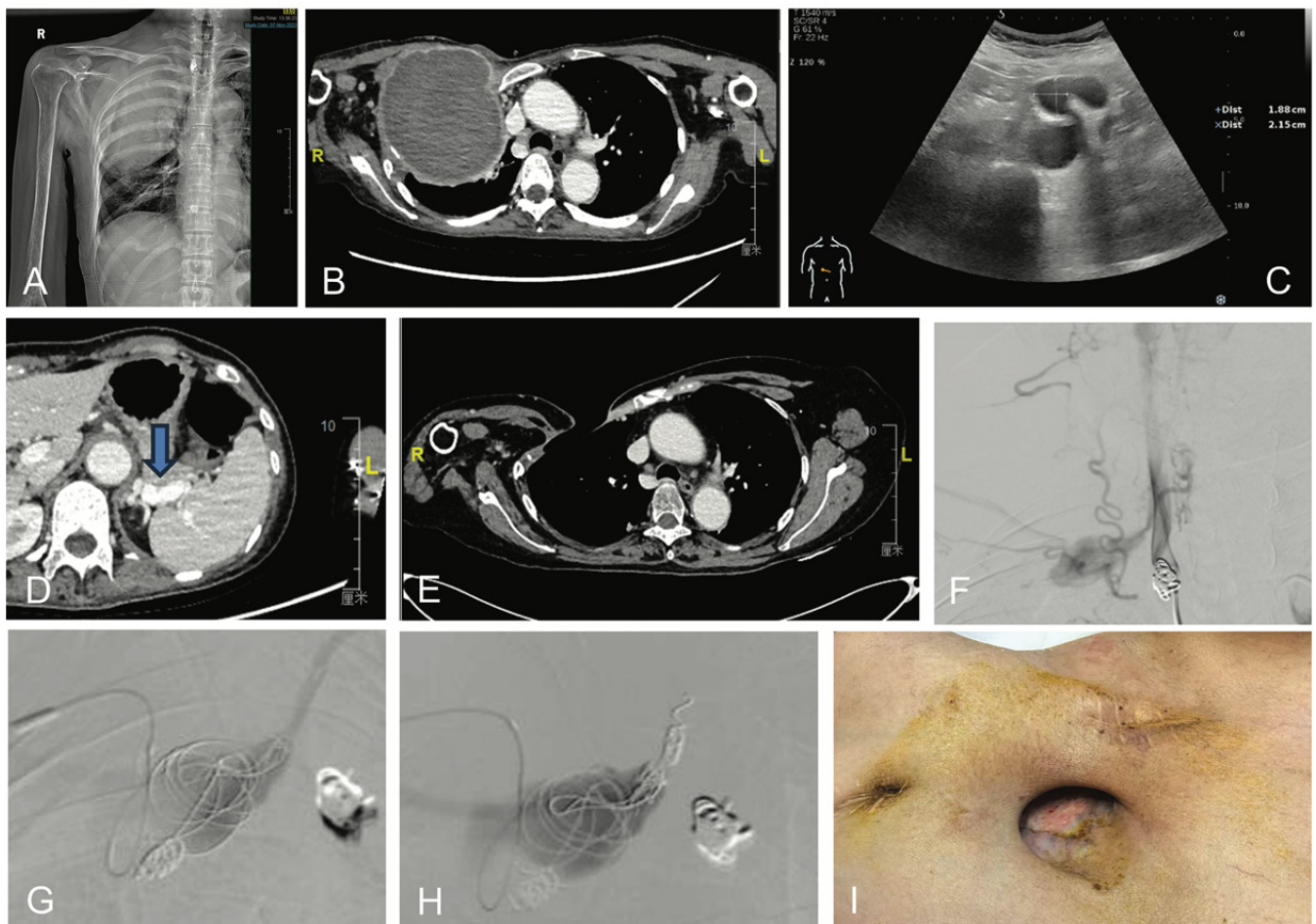
A 55-year-old woman had a 26-year history of recurrent oral ulcers. Eleven years ago, her condition gradually progressed to involve ulcer vulvae, erythema nodosum, and uveitis. Two years prior to presentation, a roundish, slightly hypodense mass (11.94cm × 17.28cm) was identified on her right chest wall, accompanied by minimal peripheral punctate calcifications and ruptured haemorrhage. Imaging revealed that the mass was partially communicating with the subclavian artery, strongly suggesting a pseudoaneurysm at the clavicular segment of the right subclavian artery (Fig. A). Concomi-

tant findings included erosive bone destruction of the adjacent 1st to 4th ribs (Fig. B), as well as aneurysmal dilatation of the coeliac trunk (Fig. C) and proximal splenic artery (Fig. D), with maximum diameters of 2.15 cm and 1.6 cm, respectively.

Laboratory investigations were performed, antinuclear antibody, anti-neutrophil cytoplasmic antibody, and anticardiolipin antibody panel were all negative; complement components (C3, C4) and immunoglobulins (IgG, IgA, IgM) were within normal ranges; and tumour markers showed no abnormalities. Pathological biopsy of

the chest wall mass demonstrated no lymphoproliferative disorders, vasculitis-specific pathological changes, or neoplastic cells, thereby ruling out lymphoproliferative diseases, malignant tumours, and other definite vasculitides. The patient was diagnosed with vascular-involved Behçet's disease.

Twenty-three months ago, the patient underwent percutaneous right subclavian artery angiography combined with embolisation of the pseudoaneurysm at the clavicular segment of the right subclavian artery in another hospital's vascular surgery department. Post-operatively, the right chest wall



mass significantly decreased in size (Fig. E). Sixteen months ago, the right pseudoaneurysm re-bled spontaneously (Fig. F). The vascular surgery team then performed upward packing of the diseased blood vessel (presumed to be the costocervical trunk) via the pseudoaneurysm (Fig. G-H; additional images are available in the Supplementary material). No further intra-aneurysmal bleeding occurred after this procedure, though a 4 cm × 4 cm sinus tract remained on the right chest wall (Fig. I). The Rheumatology Department initially administered prednisone (50 mg/day) combined with cyclophosphamide (cumulative dose: 15.4 g). The

regimen was gradually transitioned to mycophenolate mofetil (1.5 g/day) for maintenance therapy. Following treatment, inflammatory markers showed a gradual decrease (erythrocyte sedimentation rate: 51 → 29 mm/h; C-reactive protein: 36.7 → 16.6 → 12.92 → 8.2 mg/L), and the right chest wall wound exhibited progressive healing.

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