Sir,

Retro aortic left renal vein (RALRV) is a rare anomaly; its incidence reported in literature is between 0.6 to 3.7%. Inadvertent injury during surgery can lead to significant morbidity. The operative technique of dealing with RALRV during open aortic surgery is not well described in the literature.

A 71-year gentleman underwent open surgery for a 3.7 cm abdominal aortic aneurysm (AAA) and a 6.6 cm right common iliac artery (CIA) aneurysm, with an incidental finding of a RALRV (Figures 1 and 2) on CT scan. Due to some adverse anatomical features, endovascular aneurysm repair (EVAR) was precluded. During the operation, after gaining optimal exposure of neck of the aneurysm, the RALRV was dissected close to the inferior vena cava (IVC) origin and to the left of the neck of aneurysm. The RALRV was then slung on either side of neck of the aneurysm, before clamping the abdominal aorta. Bleeding from the RALRV was encountered when over-sewing a lumbar artery. The slings around the vein were tightened but were insufficient to control bleeding. The neck of AAA was, therefore, divided to gain access to the RALRV, in order to repair it. In this case, it was considered safest to ligate the RALRV. There was a transient rise in serum creatinine of patient after surgery.

Based upon this case, we recommend that a RALRV should be dissected out and controlled with slings when encountered in open AAA surgery. The aneurysm neck may have to be divided to gain access to RALRV. If attempted repair is impossible then RALRV and its branches can usually be ligated without permanent sequelae.

REFERENCES