



Fig. 2 Arteriography shows a rudimentary left superficial femoral artery collateral vessel (SFA-C) reconstituting the supragenicular popliteal artery.

sciatic artery arises from early atheromatous degeneration; although the origins are not entirely clear, there may be extrinsic mechanical and intrinsic causes.^{3,7,8,12} Compression against the sacrospinal ligament and piriform muscle may occur. Furthermore, major arteries usually run on the flexor aspects of articulations, but the sciatic artery runs posteriorly in the buttocks and thigh and can become stretched. Sciatic artery aneurysms typically form under the gluteus maximus at the level of the greater trochanter. Arteriomegaly occurs frequently in persistent sciatic artery, and local embryologic congenital defects in the collagen-vascular makeup of the sciatic artery may be a factor.

Patients who have persistent sciatic artery most often present with limb ischemia, which often threatens the limbs¹³; to the best of our knowledge, ischemic presentation in the circumstance of trauma is heretofore unreported. Aneurysmal formation is signified by gluteal pain or by a painful, pulsatile mass in the buttocks. When the sciatic artery lies within the sciatic nerve sheath, the nerve is flattened and may cause leg pain that simulates sciatica.^{9,10} Acute limb ischemia in the presence of a sciatic artery aneurysm is usually caused by embolization, a condition that can be managed by

embolectomy, distal bypass, or thrombolysis.³ Careful angiography can delineate the anatomy, reveal the type of persistent sciatic artery, and enable the evaluation of distal runoff. However, arteriograms that originate in the external iliac artery may miss a persistent sciatic artery, and the patient's clinical situation might then be misinterpreted as a simple SFA occlusion.

The treatment of sciatic artery aneurysm is generally accomplished by exclusion of the aneurysm via ligation or embolization. This alone is usually sufficient to treat an aneurysm in the incomplete variant of persistent sciatic artery; however, an aneurysm in the complete variant requires lower-extremity revascularization, which is usually achieved via femoral-popliteal bypass. Several proposed surgical approaches depend on the aneurysm's anatomy. If the aneurysmal neck is intrapelvic, it can be controlled via a trans- or extraperitoneal approach.^{6,10} If the neck is completely extrapelvic, a posterolateral curvilinear incision in the buttocks and splitting of the transgluteal muscle may be performed.^{10,13} A patent sciatic artery that has become aneurysmal can be treated by aneurysmorrhaphy with interpositional graft placement; however, there is still a risk of the artery's being stretched or compressed when the graft