Aorto-enteric fistula has an incidence of 0.4–2.4% after conventional aortic replacement and 0.7% after endovascular aortic reconstruction (EVAR). If left untreated, mortality can reach 100% and the prognosis can only be improved by structured and rapid diagnostics and interdisciplinary individualized therapy.

**Case Report:**

A 65 years-old male who was on hemodialysis due to terminal renal failure had been admitted for 3 episodes of GI bleeding during the last 2 months (Fig 1). As he had a history of open AAA replacement a CT-scan was obtained and aorto-enteric fistula was identified. (Fig 2) Surgery was planned for the same day but prior to procedure a massive GI bleeding shocked the patient. Under cardiac arrest the patient was taken to OR and an urgent EVAR was performed with a Powerlink Endologix device. (Fig 3) The patient compensated immediately after endograft placement and the following day he was awake, without assisted ventilation and without vasopressor drugs. On day 6 after EVAR he shocked again. CT scan was obtained and showed endograft in correct position with no signs of leak. (Fig 4) Blood cultures samples were obtained and levadures grew. A fungus sepsis was diagnosed and treated, but the patient died with multiorgan failure syndrome 26 days after EVAR.

**Discussion:**

Open debridement and in situ reconstruction or two stages axilo-bifemoral bypass followed by aortic debridement and bowel reconstruction has a mortality as high as 50%. Delivering an endovascular graft in an infected environment is controversial and against general surgical principles. Nevertheless, it can be considered a bridge in shocked-bleeding patients until hemodynamic compensation is reached and a definitive open repair can be done.

**Conclusion:**

Endovascular therapy can be an alternative therapy in individual cases but only as a bridging procedure up to definitive open repair.