

Acute Mesenteric Ischaemia

Acute mesenteric ischaemia is an uncommon but catastrophic acute surgical emergency. It carries a high morbidity and mortality. It represents a diagnostic challenge, and therefore a high index of suspicion is required, as patients often present with a paucity of physical signs despite severe abdominal pain. Suspicion should be heightened where risk factors exist – cardiac arrhythmias, past history of thrombotic events, B.M.I. 30+, smoker, thrombotic medication. Prompt diagnosis and aggressive management is required. If the diagnosis is suspected and there are signs of peritonitis or there is suspicion that some other urgent abdominal condition exists, urgent laparotomy is indicated. If these abdominal signs are absent further urgent investigations may help to establish the diagnosis before irreversible changes occur.

It is hoped that the following suggestions may help some patients to be treated successfully, although it is recognised that the majority of patients will be diagnosed too late for any successful intervention.

1. In a patient with symptoms of severe abdominal pain, vomiting, and/or diarrhoea, who on physical examination has few signs – suspect mesenteric ischaemia (bowel sounds are often present in the early stages).
2. When mesenteric ischaemia is suspected as a cause of the abdominal symptoms, obtain an urgent angiogram/CT angiogram.
3. When an angiogram confirms the diagnosis, undertake a vascular reconstruction urgently. Involvement of a vascular surgeon is indicated if available.
4. When a vascular correction (embolectomy or bypass) has been performed, obviously dead bowel can be resected and the ends brought out as stomata. Bowel of doubtful viability should be returned to the abdomen and a "second look" laparotomy performed within 24 hours.
5. If angiography reveals venous thrombosis or non-occlusive mesenteric ischaemia consider the use of anticoagulants or vasodilators.

Note: Acute mesenteric ischaemia is usually due to obstruction of the superior mesenteric artery. Access to the origin of this vessel is difficult, but is not necessary. Access can be obtained beyond the transverse mesocolon, that is, distal to the origin of the middle colic artery. An arteriotomy here can enable the passage of embolectomy catheters proximally and distally, or the attachment of a vein bypass from the aorta or a common iliac artery.

References

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