

Images in...

Superior mesenteric artery dissection

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DESCRIPTION

A 61-year-old man presented with a 2-day history of epigastralgia and back pain without nausea, vomiting, haematemesis or melena. He reported that he had untreated hypertension. On examination, his upper extremity blood pressures were 180/100 (right arm) and 177/98 mm Hg (left arm). His abdomen was soft and flat, but showed epigastric tenderness without rebound tenderness or muscle rigidity with normal bowel sound. Abdominal ultrasonography revealed decreased blood flow at the proximal portion of superior mesenteric artery (SMA). Abdominal CT with contrast enhancement revealed dissection of SMA from the proximal portion to the ileal artery bifurcation (figures 1 and 2). There was no intestinal wall thickening or gastric intramural emphysema. His pain resolved with

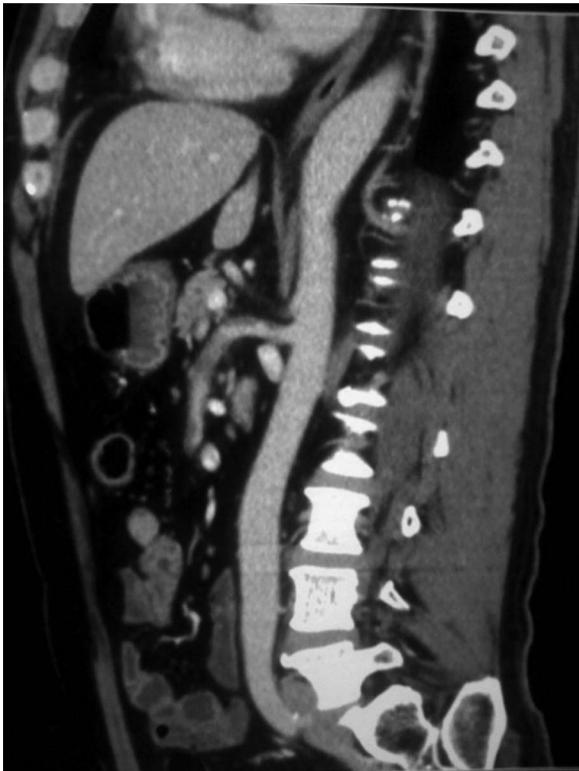


Figure 1 Sagittal section of superior mesenteric artery.

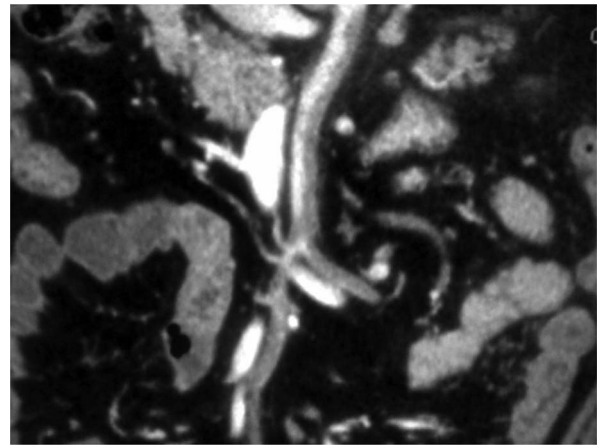


Figure 2 Coronal section of superior mesenteric artery.

conservative management. He was discharged after the symptoms disappeared. He did not have recurrence of the symptom and there was no change in diameter of the false lumen in the follow-up investigation 6 months after the discharge.

Isolated SMA dissection is rare; risk factors include hypertension, trauma, atherosclerosis and connective tissue disorder.¹ Its diagnosis is usually made by contrast-CT scan. As this case, most patients with SMA dissection can be successfully managed with conservative treatment. Surgical treatment or percutaneous intervention can be reserved for patients with severe mesenteric ischaemia and those for whom the initial conservative treatment fails.² After conservative treatment, the majority of patients show clinical improvement.³

Competing interests None.

Patient consent Obtained.

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