ACUTE MESENTERIC ISCHEMIA

I. ETIOLOGY

A. Embolization to SMA –50%

B. Thrombosis at origin of SMA – 25%
   i. Areas of critical stenosis – usually at origin
   ii. Unheralded event or acute exacerbation in patient with chronic symptoms
   iii. Angiography prior to O.R.
   iv. Emergent: retrograde with vein is optimal

C. Nonocclusive mesenteric ischemia
   i. Low blood flow from MI, sepsis
   ii. Vasoactive drugs (digoxin)
   iii. Treat underlying illness, stop pressors

D. Vasculitis and small vessel disease
   i. Lupus, scleroderma, amyloidosis
   ii. Segmental, and needs resection, not revascularization if surgical intervention needed
   iii. Treat underlying disease

E. Mesenteric venous thrombosis
   i. Obstruction vs. hypercoagulability
   ii. Anticoagulation

II. ACUTE SMA EMBOLIZATION

A. Location and Causes
   i. First 3-5 cm from origin, just past takeoff of the MCA
   ii. Usually originates from the heart with atrial fibrillation and/or MI
   iii. Any arrhythmia can cause an embolus
   iv. Atrial septal defect and atrial myxoma

B. Presentation
   i. Acute onset of severe abdominal pain
   ii. Explosive diarrhea/vomiting sometimes can occur
   iii. "pain out of proportion to physical findings"
   iv. lab tests nonspecific until late
   v. metabolic acidosis "serum lactate"

C. Diagnosis

i. Suspicion based on history and physical exam
ii. Angiography or CT scan
iii. Early diagnosis is imperative
iv. Leukocytosis, acidosis, peritonitis

D. Treatment

i. Early operative intervention critical
ii. Achieve pulsatile flow and resect any nonviable bowel
iii. Planned second look procedure if questionable viability

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