Interesting Case

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A 61-year-old man presented to the hospital with severe acute epigastric pain for 15 hours followed by fresh blood hematemesis. He denied any underlying disease. On arrival, the patient had high blood pressure, tachypnea and tachycardia. Physical examination showed mild pallor. Bowel sound was absent with mild abdominal distention and no peritoneal sign. Nasogastric lavage revealed fresh blood. His chest X-ray demonstrated a wide mediastinum (Figure 1) and a plain film of the abdomen showed small bowel ileus. He was sent for an emergent EGD. The findings are shown as Figures 2 A, B, C. Gastroduodenal infarction was suspected and he was transferred for an emergent CT of the whole abdomen including angiography. *Acute aortic dissection (Stanford type B) with hepatic and intestinal infaction was diagnosed* (Figure 3A-B). After patient had been stabilized, an explore laparotomy was done. Gangrene of gallbladder, spleen, descending and sigmoid colon were detected. Cholecystectomy, splenectomy and left half colectomy were performed. Within the same day, fenestration of infrarenal abdominal aorta to provide blood flow to the gut was also successfully done. After surgery, the patient did well without further abdominal pain and no bleeding recurred.

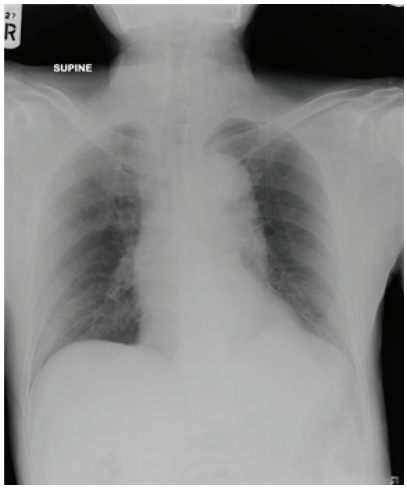

Figure 1. A Chest X-ray showing widening of mediastinum.

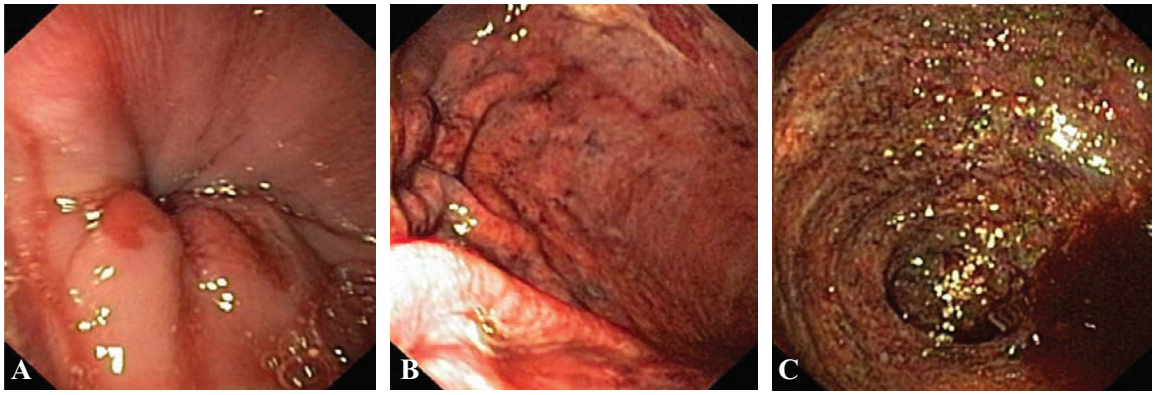

Figure 2. A. Demonstrating normal esophagus.
B & C. showing diffuse mucosal infarction containing necrotic slough of stomach and duodenum.

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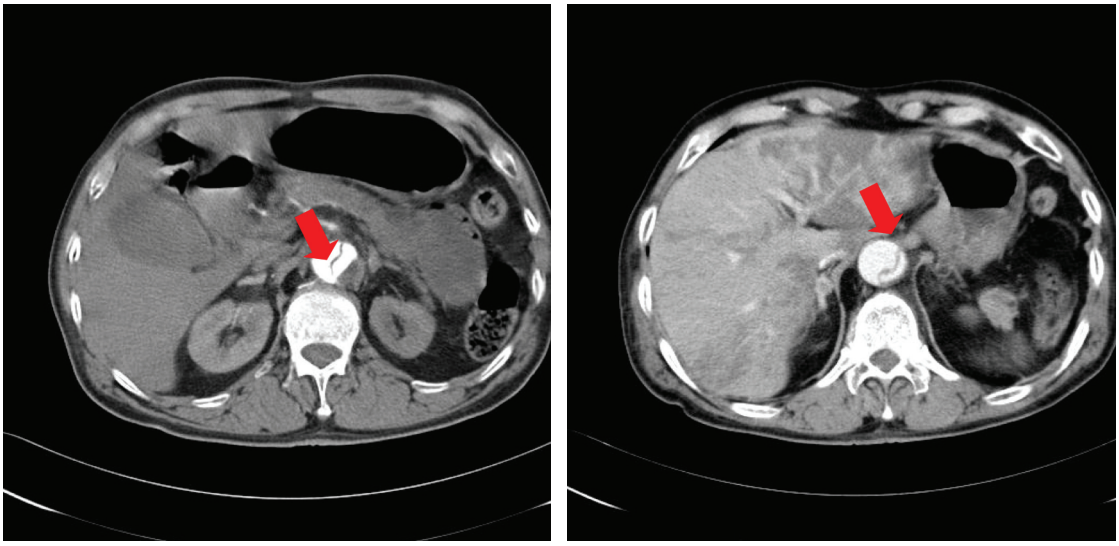

Figure 3. A. An abdominal CT scan showed aortic dissection extending from descending thoracic aorta to entire intra-abdominal aorta, occlusion of celiac axis is noted.
B. Showing hepatic infarction (red arrows indicating a false lumen).

DISCUSSSION

This patient presented with acute upper gastrointestinal bleeding from gastroduodenal ischemia was suffered from acute aortic dissection. In general, patients with uncomplicated dissecting aortic aneurysm type B are best treated with conservative therapy[1]. However, this patient had a complicated course of acute aortic dissection type B with disruption of blood flow to all major intra-abdominal aortic branches. Then emergent aortic fenestration in acute abdominal dissection was indicated to effectively relieve organ from gangrene. However, this procedure still carries a high mortality rate.[2] In contrast, endovascular stent-grafting is a less invasive alternative and has a lower morbidity rate especially in subacute and chronic dissection[3]. However, the outcome is not as good as surgery for acute dissection.[4,5]

REFERENCES

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