

CT thorax and abdomen showed marked contrast-delay; and occlusion of the coeliac trunk (known in advance), and stenotic superior mesenteric artery (Figure 3A). In addition, the inferior mesenteric artery was severely arteriosclerotic with a proximal stenosis and sparse contrast in the periphery (Figure 3B). There was pronounced oedema of the wall of the colon (Figure 3C), but no pneumatosis. Corresponding to the affection of the three mesenteric arteries and their supply areas, ventricular retention and increased wall thickness were observed in the small intestine, the descending colon, and rectum (Figure 4). Ascites and pleural effusions underlined the advanced condition.

There was no treatment to offer and the patient died about 24 hours after onset of symptoms, 8 hours after admittance. No autopsy was performed.

Discussion and Conclusion

This tetraplegic patient felt no pain but otherwise exhibited symptoms of intestinal necrosis. Initially, the symptoms did not lead to the proper diagnosis although she had several risk factors for arteriosclerosis, known affection of the mesenteric arteries and aggravation of mesenteric low-flow due to excess ingestion of beta-blockers with classic EKG changes, severe bradycardia and hypotension, and reactive mesenteric vasospasm due to autoregulation [4,5].

Diagnosing Acute Mesenteric Ischemia (AMI) involves a combination of clinical suspicion and imaging. Laboratory tests are typically nonspecific. As the disease progresses, leucocytosis develops, and lactate levels rise late in the course due to bacterial metabolism and ongoing anaerobic metabolism suggestive of an ischemic process [1,3,7,12]. This patient had an excessively elevated S-lactate, which is consistent with colon-ischemia, but not specific. The most important test is CT angiography, and this patient offered changes characteristic of extensive intestinal ischemia and necrosis (Figures 3 and 4) [1-8].

As soon as suspicion of intestinal ischemia arises, it is imperative to initiate supportive care involving oxygen, fluid, broad-spectrum antibiotics, anticoagulation medication, and pain control while at the same time consulting a vascular surgeon and a gastric surgeon. For Non-Occlusive Mesenteric Ischemia (NOMI), vasodilatation should be considered and treatment with papaverine infusion. The treatment should restore the blood flow. The options available vary depending on the underlying cause, and early recognition and rapid treatment are critical to reduce mortality. The prognosis is severe, and when diagnosis is delayed AMI and NOMI are usually lethal [1-5,8,12].

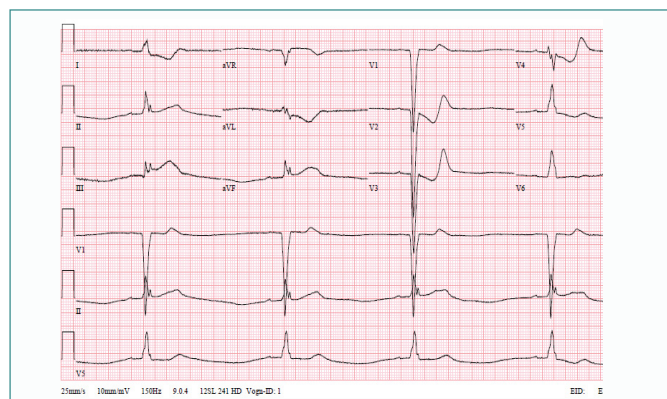


Figure 2: Sinus rhythm 26 beats/min and LBBB 160 ms - upon arrival, intoxicated with beta-blockers.

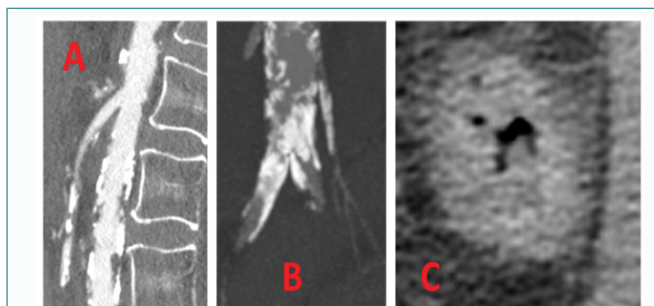


Figure 3: (A) Occlusion of the coeliac trunk and stenotic superior mesenteric artery; (B) The inferior mesenteric artery, arteriosclerotic with a proximal stenosis and sparse contrast in the periphery; (C) Pronounced oedema of the wall of the colon.

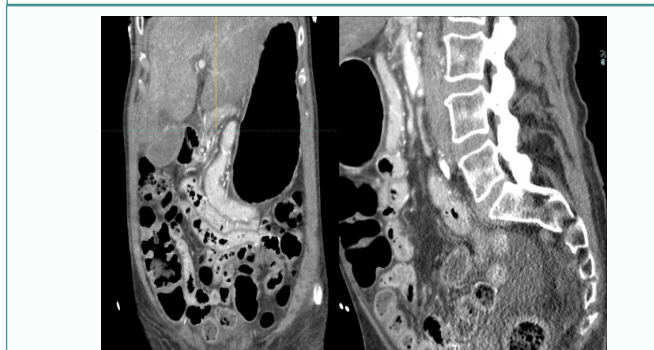


Figure 4: Ventricular retention and increased wall thickness in the small intestine, the descending colon, and rectum.

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