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AIMS AND SCOPE

The primary aim of the *World Journal of Gastrointestinal Pathophysiology* (WJGP, *World J Gastrointest Pathophysiol*) is to provide scholars and readers from various fields of gastrointestinal pathophysiology with a platform to publish high-quality basic and clinical research articles and communicate their research findings online.

WJGP mainly publishes articles reporting research results and findings obtained in the field of gastrointestinal pathophysiology and covering a wide range of topics including disorders of the esophagus, stomach and duodenum, small intestines, pancreas, biliary system, and liver.

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Chronic mesenteric ischemia diagnosed *via* incidental CT findings with gastroenterologist perspective: Two case reports

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Abstract

BACKGROUND

Chronic mesenteric ischemia (CMI) is a rare but serious cause of postprandial abdominal pain and weight loss, often diagnosed late.

CASE SUMMARY

We report two cases with prolonged history of vague abdominal pain, early satiety, and significant weight loss. Extensive workups for functional and structural gastrointestinal disorders were unrevealing. The diagnosis was ultimately prompted by gastroenterologist re-review of prior computed tomography abdomen studies – performed earlier during the investigation but not specifically targeting the mesenteric vasculature. On close inspection, both scans revealed extensive vascular calcifications involving the superior mesenteric and celiac arteries, which had not been mentioned in the original radiology reports. Subsequent dedicated vascular imaging confirmed significant mesenteric artery stenosis. Both patients underwent successful endovascular intervention with complete resolution of symptoms.

CONCLUSION

These cases highlight the importance of clinician-led image review and maintaining a high index of suspicion for CMI in elderly patients with unexplained gastrointestinal symptoms presenting to the gastroenterology department.

Key Words: Chronic mesenteric ischemia; Postprandial pain; Vascular calcification; Computed tomography imaging; Diagnostic delay; Endovascular intervention; Gastrointestinal ischemia; Case report

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Core Tip: Chronic mesenteric ischemia should be considered in elderly patients with unexplained postprandial pain, weight loss, and risk factors for atherosclerosis. Prompt diagnosis enables minimally invasive treatment and can prevent progression to acute mesenteric ischemia, which carries high morbidity. Clinician-led suspicion and re-review of already available imaging may aid in establishing the diagnosis with reduced delays and improved patient outcomes.

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INTRODUCTION

Chronic mesenteric ischemia (CMI) is a potentially life-threatening condition[1] caused by insufficient blood flow through the mesenteric arteries, typically due to atherosclerotic stenosis[2]. Although being rare - comprising less than 1 in 1000 of all admissions for abdominal pain in the United States[3], it is increasingly recognized among elderly patients with cardiovascular risk factors[4]. The classic presentation includes postprandial abdominal pain, weight loss, diarrhea and food aversion especially in older female individuals where this condition is overrepresented[4,5]. Despite this, CMI remains underdiagnosed due to nonspecific symptoms and overlapping presentations with more common gastrointestinal conditions, leading to diagnostic delays[6,7]. Imaging plays a key role, yet mesenteric vessel abnormalities may be overlooked especially when the interpreting radiologist is not explicitly asked to look at these vessels[8].

In this report, we present two cases where CMI was diagnosed after significant delays, thanks to careful computed tomography (CT) review by a gastroenterologist, leading to successful intervention and outcomes.

CASE PRESENTATION

Chief complaints

Case 1: A 76-year-old woman was referred to the gastroenterology department with a 15-month history of postprandial abdominal discomfort, bloating, diarrhea, early satiety, and unintentional weight loss of 27 kg.

Case 2: A 71-year-old woman was referred to the gastroenterology department due to a 12-month history of vague upper abdominal pain, significant weight loss (12 kg), early satiety and diarrhea.

History of present illness

Case 1: The aforementioned symptoms had worsened progressively over the preceding 15 months with extensive evaluations including upper and lower endoscopies and abdominal CT scans, all of which were non-diagnostic.

Case 2: The patient reported similarly progressive symptoms for the past year. Multiple GI investigations through her general practitioner were unrevealing.

History of past illness

Case 1: History of quiescent giant cell arteritis (GCA), inactive for over a decade without corticosteroid therapy. She also had hypertension and hyperlipidemia.

Case 2: History of hypertension, hyperlipidemia and prior (13 years earlier) stenting of the right common iliac artery due to symptomatic peripheral arterial disease.

Personal and family history

Both patients denied any significant family history of gastrointestinal disorders.

Physical examination

Non-contributory in both cases. Abdominal examination was benign with no signs of peritonitis or palpable masses.

Laboratory examinations

Case 1: Fecal calprotectin mildly elevated (250 mg/kg). Other labs within normal range.

Case 2: Laboratory tests were unremarkable.

Imaging examinations

Case 1: The gastroenterology registrar re-reviewed the prior abdominal CT, which had been performed months earlier as

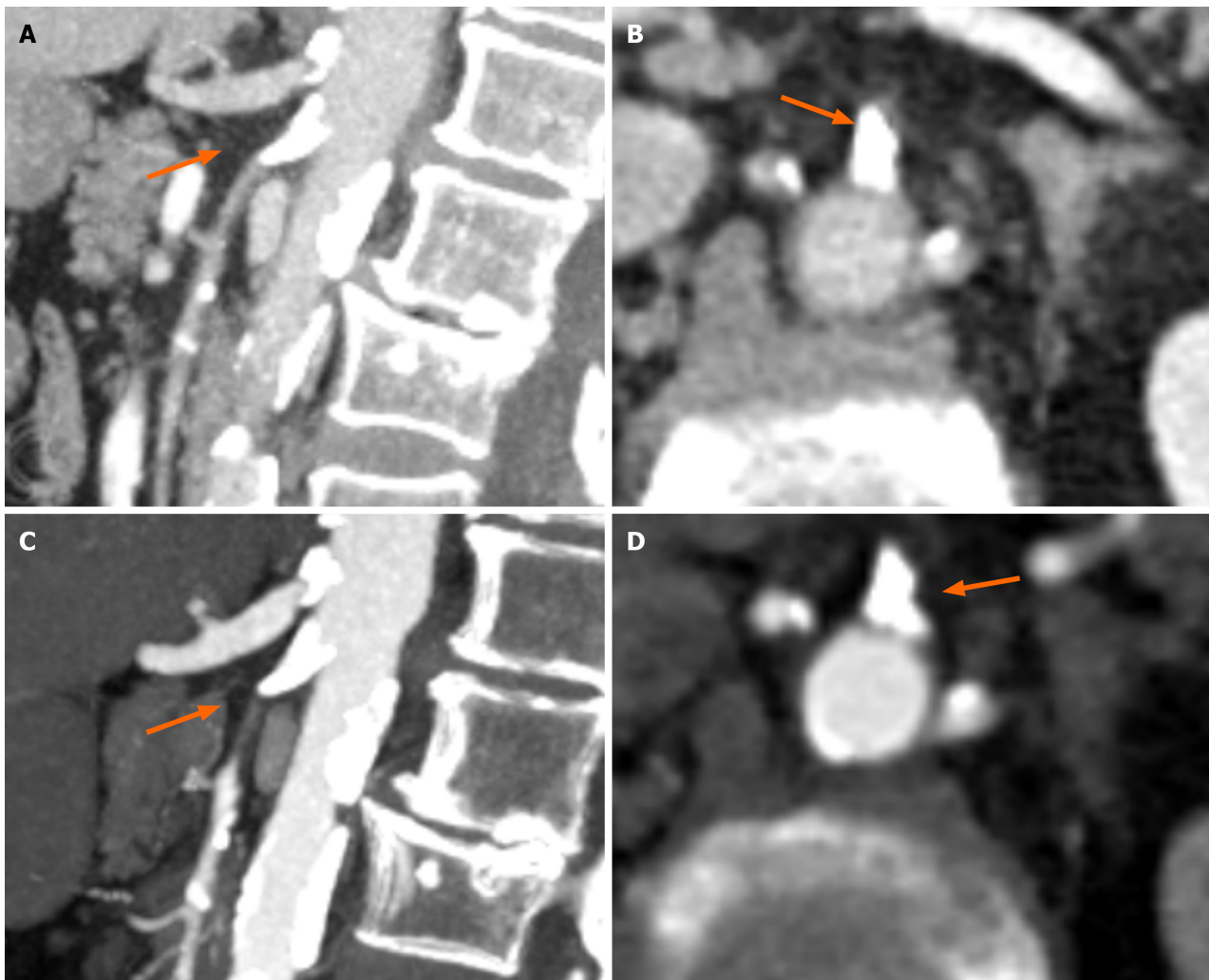


Figure 1 Computed tomography abdomen protocol and angiography protocol. A and B: Show the presence of significant calcification at both the celiac trunk and superior mesenteric artery (SMA) (A: Sagittal reconstruction), with extensive calcification at the SMA ostium when viewed in axial view; C and D: Show extensive calcifications at both the celiac trunk and SMA, with a 1.5 cm portion of the SMA distal to the calcification showing vascular occlusion (C: Sagittal reconstruction), extensive calcification at the SMA ostium when viewed in axial view (D).

part of the initial work-up for non-specific abdominal pain. This review revealed extensive calcifications at the origins of the superior mesenteric artery (SMA) and celiac trunk (Figure 1A and B), which had not been reported in the original radiology interpretation. CT angiography was then performed to assess the mesenteric vasculature, confirming high-grade stenosis of the SMA with suspected 1.5 cm portion of the vessel showing occlusion (Figure 1C and D). Figure 1A and B (CT abdomen protocol) show the presence of significant calcification at both the celiac trunk and SMA (Figure 1A, sagittal reconstruction), with extensive calcification at the SMA ostium when viewed in axial view. Figure 1C and D (CT angiography protocol) show extensive calcifications at both the celiac trunk and SMA, with a 1.5 cm portion of the SMA distal to the calcification showing vascular occlusion (Figure 1C, sagittal reconstruction). Figure 1D shows extensive calcification at the SMA ostium when viewed in axial view. Given the patient's prior history of GCA, a review of the patient by a rheumatologist, alongside a positron emission tomography (PET-CT) were done to assess for the presence of clinical and/or tomographic signs of reactivation of underlying GCA. The PET-CT and the clinical exam were both negative for GCA reactivation.

Case 2: The abdominal CT performed for investigation of the patient's symptoms several months prior was re-reviewed by the gastroenterology registrar, revealing marked calcification at the SMA and celiac origins, not mentioned in the radiology report (Figure 2A and B). CT angiography confirmed high-grade stenosis of the SMA (Figure 2C and D). Figure 2A and B (CT abdomen protocol) show the presence of significant calcification at both the celiac trunk and SMA (Figure 2A, sagittal reconstruction), with extensive calcification at the SMA ostium when viewed in axial view. The SMA show extensive calcification along the entirety of its length especially in sagittal view. Figure 2C and D (CT angiography protocol) show extensive calcifications at both the celiac trunk and SMA (Figure 2C, sagittal reconstruction). Panel D shows extensive calcification at the SMA ostium when viewed in axial view.

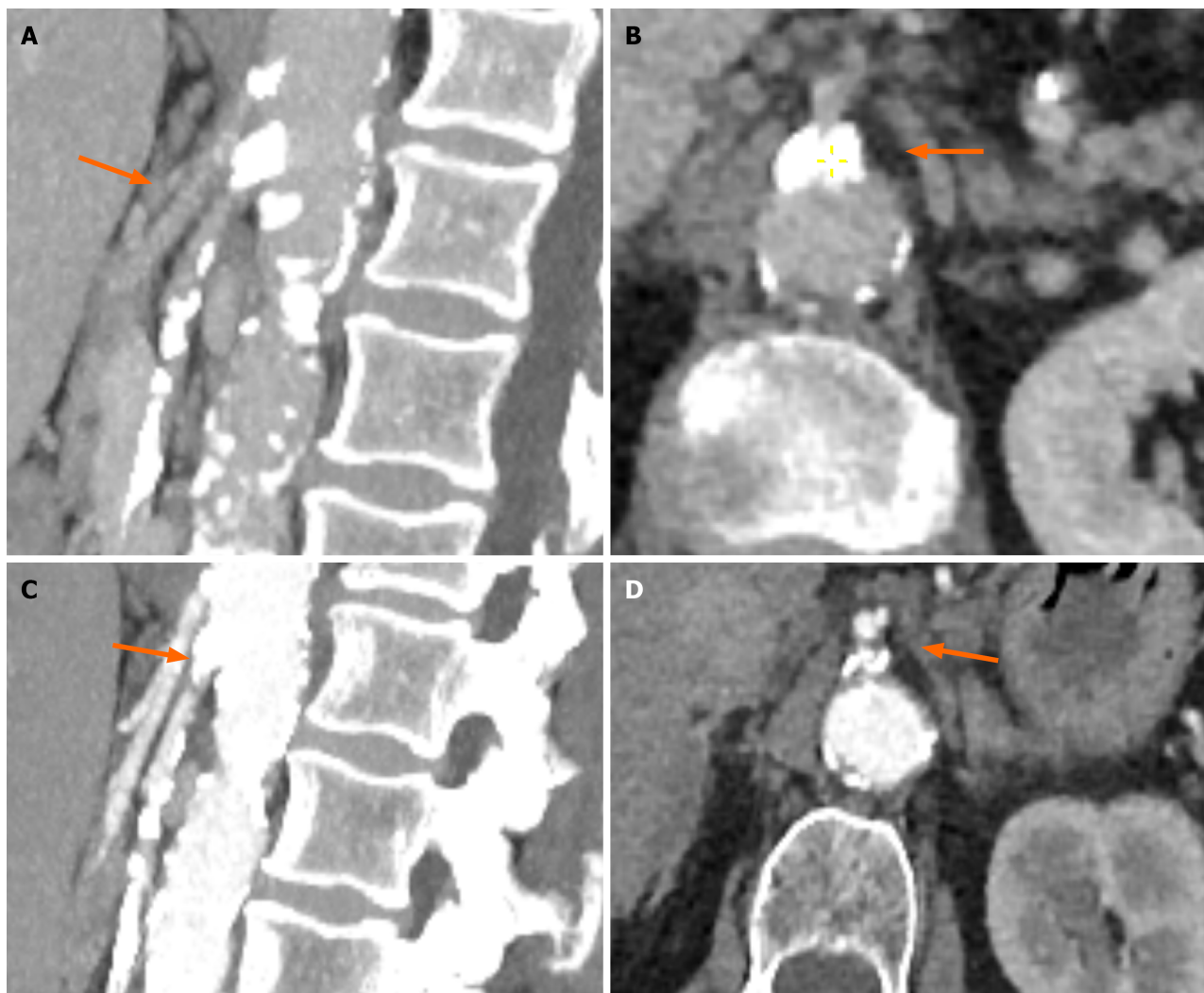


Figure 2 Computed tomography abdomen protocol and angiography protocol. A and B: Show the presence of significant calcification at both the celiac trunk and superior mesenteric artery (SMA) (A: Sagittal reconstruction), with extensive calcification at the SMA ostium when viewed in axial view. The SMA show extensive calcification along the entirety of its length especially in sagittal view; C and D: Show extensive calcifications at both the celiac trunk and SMA (C: Sagittal reconstruction), extensive calcification at the SMA ostium when viewed in axial view (D).

FINAL DIAGNOSIS

Chronic mesenteric ischemia in both patients due to atherosclerotic disease of the superior mesenteric artery.

TREATMENT, OUTCOME AND FOLLOW-UP

Both patients were referred to the vascular surgery service for further management and endovascular stenting. The patients underwent successful percutaneous angioplasty with stenting, demonstrated as completion angiograms in [Figure 3](#) (Case 1) and [Figure 4](#) (Case 2). Both figures show patent SMA with good contrast filling distally, indicating restoration of adequate mesenteric blood flow. Case 1 had regained approximately 5 kg 11 months post-endovascular intervention with resolution of post-prandial pain. Case 2 had regained approximately 8 kg 6 months post endovascular intervention with resolution of post-prandial pain.

DISCUSSION

These cases highlight the diagnostic challenges of CMI, particularly in the elderly population where nonspecific symptoms may mimic functional gastrointestinal (GI) disorders[9]. In both cases, the diagnosis was delayed by over a year despite multiple evaluations and diagnostic tests. Such delays are, however, not uncommon and have been reported in multiple instances in the literature with regards to the diagnosis of CMI[10]. This underscores how imaging findings may be underappreciated when mesenteric vasculature is not the focus of the imaging study or the referral question[11,12].



Figure 3 Completion angiography following stenting (arrow) of the superior mesenteric artery. The superior mesenteric artery is patent with good contrast filling distally, indicating adequate mesenteric blood flow.



Figure 4 Completion angiography following stenting (arrow) of the superior mesenteric artery. The superior mesenteric artery is patent with good contrast filling distally, indicating adequate mesenteric blood flow.

The delay in diagnosis in both cases may be due to underappreciating vascular calcification present on available CT images against a background of an extensive yet “negative” standard workup for GI issues, which may in itself suggest non-sinister pathology. Unless mesenteric ischemia is suspected and explicitly communicated to the radiologist as part of the diagnostic referral question, vascular structures may not be systematically reviewed – particularly in elderly patients with multiple comorbidities where the presence of vascular calcification may be considered incidental and not always correlating to mesenteric ischemia[13]. Furthermore, radiologists may overlook mesenteric artery calcifications due to fatigue or distraction in high-volume practice where concise reports are required to meet productivity targets[14,15]. In such a setting, and as demonstrated in this report, clinician-led imaging review may aid in establishing a diagnosis. Such practice, however, is far from standard[16], yet it should be considered whenever patients with unexplained abdominal pain present to the gastroenterology department. This emphasizes the importance of high clinical suspicion and proactive imaging interpretation[17]. Reviewing the available CT images using sagittal reconstructions – which are nowadays automatically generated by the radiology software without needing extra steps – may aid in easier visualization of certain pathologies such as mesenteric vascular calcifications to the non-radiologist[18].

Treatment of CMI has shifted from open surgical revascularization toward minimally invasive endovascular approaches, with angioplasty and stenting now considered first-line in most patients[4,19]. Both patients in this report underwent successful percutaneous stenting and experienced prompt and sustained improvement, including weight gain and full resolution of gastrointestinal symptoms. While a detailed discussion of endovascular or surgical management strategies lies beyond the scope of this case report, this case adds to the growing body of evidence emphasizing the cri-

tical need for early recognition and multidisciplinary input[20]. A recent cross-sectional study[21] found that although healthcare professionals demonstrated adequate knowledge of mesenteric ischemia, their attitudes and clinical practices regarding the diagnosis were suboptimal, with frequent reports of delayed or missed diagnoses in suspected cases. These findings highlight an important systemic gap in awareness, reinforcing the importance of reporting rare presentations such as ours to aid earlier recognition and in effect to reduce morbidity and mortality associated with CMI.

CONCLUSION

CMI should be considered in elderly patients with unexplained postprandial pain, weight loss, and risk factors for atherosclerosis. Prompt diagnosis enables minimally invasive treatment and can prevent progression to acute mesenteric ischemia, which carries high morbidity. Clinician-led suspicion and re-review of already available imaging may aid in establishing the diagnosis with reduced delays and improved patient outcomes.

FOOTNOTES

Author contributions: Abdulrasak M contributed to conceptualization, literature review, drafting of the manuscript, critical revisions, and final approval; Wernehov I contributed to the data collection, literature review, assistance with drafting, and critical revision of the manuscript; Holmgren H contributed to the critical review of methodology, manuscript editing, and final approval; All authors have read and approved the final version of the manuscript.

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