

A Superior Mesenteric Artery Aneurysm: About A Case Report

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Introduction

Mesenteric artery aneurysms are rare and represent 0.1% of all arterial aneurysms. The superior mesenteric artery is the predilected site for these aneurysms and is associated with an increased risk of rupture.

Several etiologies can be in cause but the main cause remain the infectious state especially in young adults. In older patients, it is mainly atherosclerosis and fibro-dysplastic diseases.

Case Report

This case is about a 66-year-old female patient with no significant pathological history consulting the emergency department for sudden brutal epigastric pain. An abdominal CT angiography was done showing an image in favor of a hematoma measuring 121*69 mm in diameter located at the right parieto-colic region, encompassing a hypovascularized image of 15 mm in diameter, at the expense of a branch of the superior mesenteric artery related to an aneurysm. She was also hemodynamically stable. On intraoperative exploration, we found a non-beating thrombosed false aneurysm compacting the right colonic angle (Figure 1).



Figure 1: A false aneurysm of a branch of the AMS.

The exploration of AMS at the level of the root of the mesentery finds a well beating AMS. Our surgical approach was a flattening of the aneurysm with evacuation of the hematoma (Figures 2,3). The vascular breach was found and sutured. The postoperative was simple and the patient was discharged after four days of the surgery.



Figure 2: Thrombosis of the false aneurysm.



Figure 3: The false aneurysm after its flattening.

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Discussion

Superior mesenteric artery aneurysm is rare. It seems to affect men and women equally. It is more common in people over 50 years old. Unlike aneurysms reaching the other arteries whose primum moves is atherosclerosis, the aneurysm of the SMA is due in 60% of cases to an infectious cause. Haematogenous dissemination from a septic focus seems to be the most frequent way of contamination. In rare cases, the SMA aneurysm can be a way of revealing systemic vasculitis. The clinical presentation is associated with an atrocious and brutal abdominal pain. It can be associated with post prandial pain simulating a mesenteric ischemia.

The clinical presentation can sometimes be less brutal and more misleading combining nausea, vomiting and fever. CT angiography seems to be the most appropriate complementary exam, showing the exact location of the aneurysm, its size, and whether or not there is a rupture. The treatment can be either an open surgery or an endovascular approach. However, open surgery remains the gold standard. It can be either the simple flattening or exclusion of the aneurysm or a flattening associated with a revascularization gesture.

Though, it is increasingly recommended to try the endovascular alternative as first intention, when the anatomy is favourable, either by embolization or by using covered stents. The major drawback of this route is the risk of collateral hedging.

Conclusion

Mesenteric artery aneurysm is a rare entity. The diagnosis is often overlooked because of a misleading clinical presentation. The etiology is dominated by infectious pathologies. Open surgery remains the gold standard but the endovascular approach is increasingly considered.