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Key words: Mesenteric ischaemia. Subacute occlusive mesenteric ischaemia.

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A 74-year-old patient, with a history of arterial hypertension, dyslipidemia and atrial fibrillation in treatment with edoxaban, presented to our emergency department with melena for 24 hours, associated with postprandial abdominal pain, predominantly in the epigastrium, for one month.

Urgent gastroscopy showed a pale mucosa with loss of vascular pattern in the gastric antrum, as well as several superficial ulcers, Forrest III, at that level and in the duodenal bulb (Image 1), highly suggestive of ischaemia. An abdominal computed tomography angiography (CTA) revealed a filiform celiac trunk, with calcified atherosclerotic plaques in the ostium, superior mesenteric artery and both renal arteries, with absence of enhancement in a large part of the intestinal wall, suggestive of ischaemia (Image 1). An exploratory laparoscopy confirmed patchy ischaemia of the small intestine, as well as of the cecum, ascending colon, and portion of the transversus, ruling out the intervention given its extension.

Atherosclerosis is the most common cause of occlusive chronic mesenteric ischaemia, most often located at the origin of the artery. The 'classic triad' consisting of postprandial pain, weight loss and abdominal bruit, is found in only a minority of patients, with a significant percentage of paucisymptomatic patients due to abundant colateral circulation, making diagnosis difficult.[1].

The endoscopic finding of edema, erythema or signs of mucosal atrophy, as well as gastric or duodenal ulcers, not justified by other causes (NSAIDs consumption, H. pylori

infection, etc.), can guide us in the diagnosis of ischaemia. However, more distal sections of the digestive tract which are not accessible with the conventional endoscope can often be affected, and the absence of these findings, does not exclude the diagnosis. [2,3,4]. Abdominal CTA is the gold-standard imaging test, reserving the angiography for therapeutic purposes.[5].

Early diagnosis of mesenteric ischaemia is a challenge in clinical practice. Recognizing its signs at a clinical, analytical, or even endoscopic level, can facilitate its early diagnosis and treatment, improving its survival.

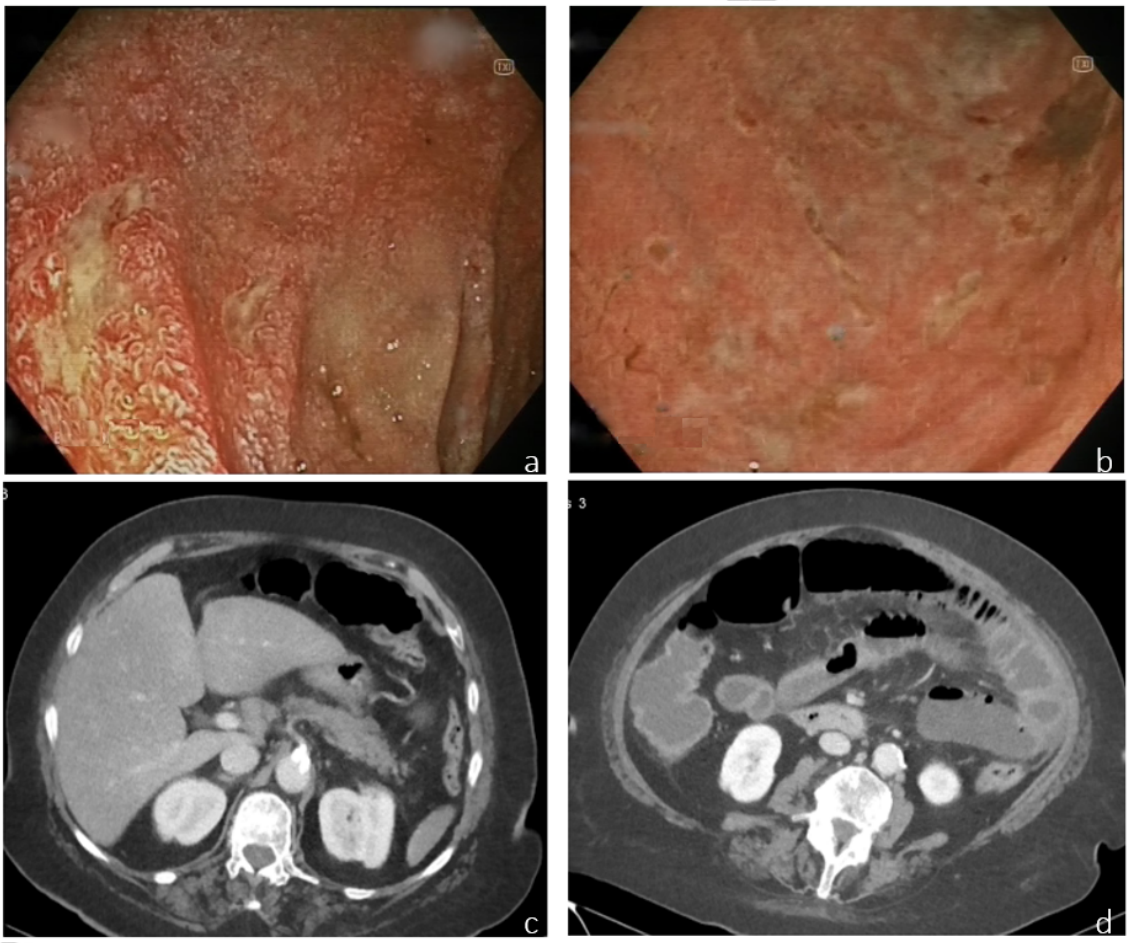

Image 1: a and b: pale mucosa with loss of vascular pattern and multiple ulcers in the duodenal bulb and the gastric antrum; c and d: calcified atherosclerotic plaques with

absence of enhancement in the intestinal Wall.

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