

CT Demonstration of Massive Enteric Bleeding in A Secondary Aortoenteric Fistula

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The critically ill female patient was presented in the emergency department hemodynamically unstable, with hematemesis and history of previous aortic reconstruction surgery due to abdominal aortic aneurysm. Esophagogastroduodenoscopy was negative for ulcer or bleeding, but multislice computed tomographic angiography (MSCTA) revealed an aortoenteric fistula (AEF). The patient was prepared for immediate surgery – aortic prosthetic graft-to-aorta anastomotic sites reconstruction and small bowel suturing. This type of surgery was chosen due to extreme hemodynamic instability of the patient, but with good one-year follow-up.

The AEF is pathological communication between the aorta and the bowel – a very rare condition, but with high mortality rate if not treated expeditiously. Patients usually have stomach pain, low blood pressure, high heart rate and some have herald bleeding¹ – couple small episodes of prodromal “gastrointestinal” bleeding before a major, lethal, bleeding. Patients may (secondary AEF) or may not have previous aortic reconstruction (primary AEF). The condition is very urgent to deal with, but it is extremely difficult to prove it with any imaging or endoscopic method, unlike the upper gastrointestinal tract bleeding, which is the first differential diagnosis.

Figure 1 presents sagittal-view reconstructions which very clearly show iodine contrast transferring from the aorta directly into the bowel (arrowed) – an explicit proof of AEF as a cause of this patient’s condition.

Even though it usually has negative result in proving of AEFs,

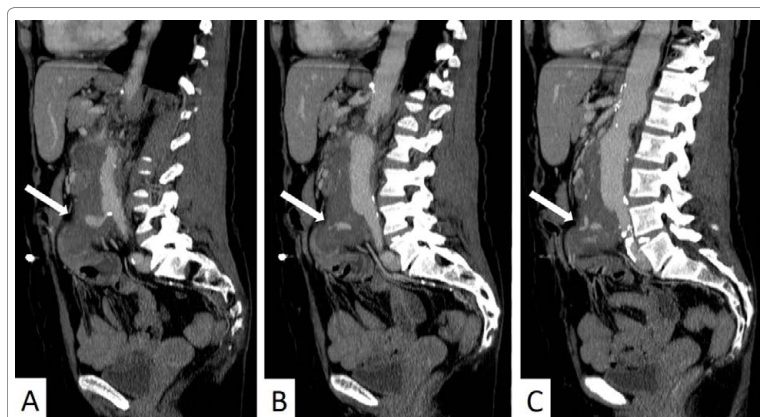


Figure 1: Aortoenteric fistula on MSCTA (sagittal view reconstructions) – iodine contrast transferring from the aorta directly into the bowel (arrowed)

the computed tomographic angiography should always be performed if suspected to AEF due to necessity of aortic reconstruction. Urgent surgery is the treatment of choice, but with uncertain prognosis.

References

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