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Summary

Management of mesenteric ischemia

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UEG Postgraduate Teaching Programme Berlin 2025 | Presentation

Radiology & Imaging | Small Intestine & Nutrition

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The speaker presented therapeutic approaches for acute and chronic mesenteric ischaemia, emphasizing an endovascular-first strategy for acute cases and primary stenting for chronic disease, both requiring multidisciplinary management and structured follow-up.

KEY POINTS

- For acute mesenteric ischaemia, the speaker stated that revascularization-first is recommended in current guidelines, preferably via endovascular approach in the angio suite or hybrid OR before laparotomy when feasible, though this remains a weaker recommendation dependent on local resources and availability.
- The speaker reported that meta-analyses suggest endovascular treatment may lower 30-day mortality and decrease bowel resection rates compared to open surgery, possibly due to time savings, though other analyses showed no mortality difference.
- In a case example, the speaker described a 70-year-old male treated with aspiration thrombectomy and 10 mg local rt-PA who initially improved but later required resection of 2 meters of necrotic small bowel and was discharged after two weeks.
- For chronic mesenteric ischaemia, the speaker stated that both EVS and UEG guidelines recommend endovascular repair over open surgery because short-term benefits outweigh the superior long-term patency of bypass, and secondary patency with repeated interventions approaches that of open repair.
- The speaker reported that recent evidence shows covered stents improve long-term primary patency compared to bare metal stents and are now recommended, though the speaker noted they are expensive and not always available in all sizes.
- The speaker recommended duplex ultrasound surveillance at 1, 6, and 12 months in the first year then annually, treatment of asymptomatic restenosis in severe cases, and dual antiplatelet therapy for 1-6 months post-procedure based on recent evidence.

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