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Summary

The clinical assessment and diagnostic work-up of mesenteric ischemia

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This educational talk reviews the clinical presentation and diagnostic workup of chronic and acute mesenteric ischaemia based on current European guidelines, emphasizing that normal laboratory values do not exclude the diagnosis and multidisciplinary evaluation is essential.

KEY POINTS

- The speaker stated that chronic mesenteric ischaemia has an incidence of 9.2 per 100,000 persons per year, comparable to Crohn's disease at 10.9 per 100,000, and presents with postprandial abdominal pain, weight loss greater than 5% of body weight, and adapted eating patterns.
- Normal lactate has only 34% sensitivity for chronic mesenteric ischaemia, and normal lactate, leukocyte counts, or gastrointestinal endoscopy do not exclude the diagnosis.
- CT angiography with one-millimetre slice thickness including arterial and venous phases is the preferred imaging modality with high sensitivity and specificity, while duplex ultrasound can be used for screening but requires additional CTA or MRA confirmation.
- In single vessel disease, the probability of chronic mesenteric ischaemia is low and diagnosis requires postprandial pain plus weight loss or adapted eating pattern after exclusion of alternative diagnoses, whereas multivessel disease has high probability and does not require functional testing.
- Visible light spectroscopy is the only currently available functional test and has high sensitivity but low specificity; the speaker noted that breath testing after meal provocation is a promising investigational modality.

- Acute mesenteric ischaemia has a mortality rate near 50% and presents in three phases including a silent phase where symptoms may decrease in intensity before clinical deterioration, and the speaker emphasized that clinicians should mention suspicion of acute mesenteric ischaemia in CTA referrals and not postpone intervention in patients with progressive symptoms.

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