Surgical Bail Out after Failed Endovascular Revascularization for Mesenteric ischaemia in Systemic lupus victim

CLINICAL HISTORY:
63 years old female with two decades history of systemic lupus on immunosuppressive therapy not known hypertensive or diabetes mellitus presented at October 2019 with typical presentations of mesenteric arterial ischaemia with progressive course of postprandial pain, weight loss and food fear, screened for other causes of abdominal pains including upper and lower endoscopy and stool cultures and all were negative. CT angiography revealed total occlusion of the origins of celiac, superior and inferior mesenteric arteries on Dec 2019 she had self-expandable stent 6x60 mm at the ostial and proximal segment of her SMA initial improvement and amelioration of symptoms was evident immediately after the procedure and was kept for two years on Jan 2022 she experienced recurrence of her abdominal pain symptoms CT angiography revealed severe in stent restenosis and short CTO distal to the stent March 2022 she had PTA of her SMA followed by DBC in spite of excellent angiographic results the patient’s symptoms were not improved much with very mild response to medical treatment follow up CT revealed long segment occlusion of SMA with very attenuated distal segment.

OPERATIVE MANAGEMENT PLANNING
Due to the extensive nature of the disease and the attenuated small caliber of the distal SMA. We choose to use the common hepatic artery as our INFLOW vessel Most of the collateral supplying the gut do arise from the left internal iliac so we choose RIGHT External iliac artery as our OUTFLOW vessel The graft was tunnel at the right paracolic/retro colic space then paraduodenal then through the foramen of Winslows to exposed common hepatic artery in supraduodenal position using triple layered PTFE graft Post operative course was uneventful with 3rd day discharge, tolerant to fluids and solid food The patient was followed up by her immunologist for her SLE management now she had been followed up for more than a year free of abdominal pains, tolerant to food and regaining her original weight.

CONCLUSION
SLE can affect any organ system, resulting in a wide range of clinical presentations. 50% of SLE patients and principally involve small vessels; medium-sized vessels can also be affected, whereas large vessel involvement is very rare. In lupus, more than any other systemic autoimmune disease, vascular disease may combine atherosclerotic, and thrombotic disease with systemic vasculitis. In our case it was an unusual acceleration of her atherosclerosis with rare isolated affection of her mesenteric arteries with absence of other vascular beds involvement. Due to the aggressive proinflammatory environment associated with SLE, we believe that endovascular treatment in this rare setting might face durability issues.

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