

## SELECTED ARTICLES

We hereby present comments on a selection of articles recently published in internationally acclaimed medical journals. We believe these papers deserve special attention due to the quality and importance of the conclusions reached by the studies. Our objective is to keep an open look on new aspects of scientific research or review articles that may, in turn, update aspects of our own medical specialty.

Also, the Editorial Committee will consider suggestions on recent articles that the readers think deserve to be commented in this section ([revista@caccv.org.ar](mailto:revista@caccv.org.ar)).

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### UPDATE ON CHRONIC MESENTERIC ISCHEMIA *HUBER TS Y COL., CHRONIC MESENTERIC ISCHEMIA CLINICAL PRACTICE GUIDELINE FROM THE SOCIETY FOR VASCULAR SURGERY*

*Journal of Vascular Surgery (2020), <https://doi.org/10.1016/j.jvs.2020.10.029>*

As head of the writing committee, Huber TS, and his staff from the Society for Vascular Surgery have just published their clinical practice guidelines for the management of chronic mesenteric ischemia.

The authors focus on 6 specific areas: diagnostic assessment, indications for treatment, treatment selection, perioperative assessment, revascularization methods (endovascular/open), and postoperative follow-ups.

Chronic mesenteric ischemia, often a cause of atherosclerosis at the origin of mesenteric arteries, often starts with postprandial pain, fear of eating, and weight loss. The diagnosis can be delayed due to the large spectrum of GI disorders that are associated with these symptoms. To exclude the possibility of GI neoplasms, the authors report that patients with symptoms compatible with chronic mesenteric ischemia should be studied immediately including esophagogastroduodenoscopy, colonoscopy, computed tomography, and abdominal ultrasound. Diagnosis is confirmed by the significant occlusion (> 70%) of the celiac trunk and the superior mesenteric artery or some of these structures only with the corresponding clinical signs. The Doppler echocardiography of the mesenteric artery is the screening procedure recommended. The definitive images are acquired on the computed tomography. However, in the presence of unusual anatomical characteristics a catheter angiography should be performed.

The targets of treatment should be to alleviate the symptoms, avoid disease progression towards acute

ischemia, and improve the patient's quality of life. The first-line treatment is the revascularization of the superior mesenteric treatment; both the celiac trunk and the inferior mesenteric artery are secondary targets because they can improve the symptoms when the superior mesenteric artery is not eligible for surgery or in cases of unacceptable treatment outcomes. Parenteral nutrition is not recommended due to the risk of clinical deterioration, intestinal infarction, and catheter-related complications. In asymptomatic patients with severe superior mesenteric occlusions, revascularization should be discussed between the patient and the heart team as a valid therapeutic option to reach agreed decisions. Endovascular revascularization with expandable balloon and intraluminal stent is advised as the first-line therapy. Open surgery is often spared for young and selected patients as well as for those who are not eligible to undergo endovascular procedures. Long-term follow-up periods are recommended after revascularization as well as in asymptomatic patients with severe mesenteric occlusion. Revascularized patients should be monitored 1 month after the procedure, and then twice a year within the first 2 years followed by 1 annual check-up. As it happens with primary cases, in patients with recurring symptoms after revascularization, the endovascular treatment should be prioritized. Also, in cases of restenosis on the Doppler echocardiography, the diagnosis should be confirmed on a CT scan or through catheterization.