



Aortic Aneurysm Characterization Using Heralded Gastrointestinal Bleeding

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DESCRIPTION

The disease known as Primary Aortic Aneurysms (PAA) has a high death rate. Most patients miss the optimal window of opportunity for treatment because they do not exhibit clear clinical symptoms in the early stages. Massive gastrointestinal bleeding can occur from an uncommon but potentially fatal abdominal aortic aneurysm called a Primary Aortic Gastrointestinal Fistula (PAGF). Even though it is uncommon, this complication is significant because, if left undiagnosed, it is typically fatal. An aortic aneurysm ruptured spontaneously into the adjacent gastrointestinal loop lumen is caused by PAGF. It is very uncommon for a fistula to form between the gastrointestinal tract and the aorta. According to estimates, the yearly incidence of PAGF is 15/million. Therefore, it can be extremely difficult to diagnose and treat an aortic aneurysm that is characterized by herald gastrointestinal bleeding. In the absence of surgical intervention, the death rate approaches 100%. Patients may die from complications like infection even if they receive timely surgical care. Even with early diagnosis and treatment, PAGF-an aberrant communication between the aorta and the gastrointestinal tract-remains a rare but potentially fatal cause of gastrointestinal bleeding, with a notable death rate. There is a high death rate: 30% to 40% of surgical patients die, and nearly 100% of untreated patients die. Although the pathophysiological mechanism is unclear, it is thought that the formation of a fistula between the two is a rare cause of gastrointestinal bleeding, accounting for less than 0.2% of cases. This is because aneurysms are continuously beating, squeezing and eroding the digestive tract

and causing ischemia and necrosis. Atherosclerosis is responsible for 85% of PAGF cases, with abdominal aortic aneurysms being the most common cause. Aortic arteritis brought on by bacteria, syphilis, and tuberculosis is among the other uncommon causes. Tumors, radiation injuries, peptic ulcers, diverticulitis, and foreign objects (like needles, fish bones, or chicken bones) are among the other uncommon causes. Anywhere from the esophagus to the sigmoid, and between the aortas, fistulas can develop. The hematoma compressed the inferior mesenteric artery's beginning, resulting in intestinal ischemia. In cases two and three, fistulas formed between the intestine and aorta and the esophagus, respectively. The clinical presentation of PAGF varies and can include the classic triad of GI bleeding, abdominal pulsating mass, and low-grade fever linked to obscure infected lesions. Only one of our patients experienced stomach pain; the other patients all had GI bleeding. The first bleeding after catastrophic exsanguinations is known as the sentinel hemorrhage. It typically stops on its own and is mild because thrombus plugs the fistula due to hypotension. But once the patient's blood pressure returns to normal, the plug could come loose from its canal and cause more bleeding. Sentinel hemorrhage is recurrent, with a few hours to several months elapsing between the first hemorrhage and the final exsanguination. This time interval varies from 11 hours to 4 days in our study. The patients experienced hypovolemic shock during the initial sentinel hemorrhage, which led to death. To diagnose PAGF as soon as possible, a high index of suspicion is necessary. No single examination can definitively diagnose the condition in the absence of clinical suspicion.

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