Case	(594) Acute perforated jejunal diverticulitis nearby aortic aneurysm.
Authors	A. Mañas Hernandez, C. Arizaga Ramirez, A. Nava Muñoz, L. Escudero Gonzalez, L. Sanz Canalejas, M. Bertolez Cue.
Centre	Hospital Clinico San Carlos.

CASE PRESENTATION

A 86-year-old man with cardiovascular risk factors was admitted to the emergency department due to fever, holocraneal headache, confusion and gait instability in the past week. Three days ago he began with abdominal pain in the left iliac fossa. On physical examination, he presented diffuse abdominal tenderness.

Leukocytes where within normal range but polymorphonuclears were increased. An abdominal x-ray was requested showing left side paravertebral linear calcifications suggestive of an abdominal aortic aneurysm. An abdominal ultrasound was performed, which confirmed this finding as well as the presence of a mural thrombus in its interior without periaortic fluid.

However, during the ultrasound examination it caught our attention the intense abdominal pain at the moment the transducer compressed the zone of the aneurysm; thus a CT was promptly requested to rule out any vascular complication.

The CT findings showed no signs of aneurysm complications. Instead, adjacent to it, a jejunum diverticulum with subtle inflammatory changes and extraluminal intraperitoneal air bubbles was visualized. Final diagnose of acute perforated jejunal diverticulitis responsible of the patient acute abdominal pain was made. The patient was treated conservatively with prolonged antibiotic therapy.

Once the acute episode was resolved and during the same hospital admission, he was scheduled for an aorto-bi-iliac prosthesis placement procedure.

DISCUSSION

The acute abdomen syndrome represents one of the main causes of visits to emergency services. In elderly it is challenging being able to determine its etiology due to unspecific clinical presentation. It is therefore important to properly manage diagnostic imaging options in order to determine the underlying cause.

Abdominal radiography played an important role as the first diagnostic imaging tool requested because it revealed the existence of an aortic aneurysm and raised the possibility of a vascular condition causing the abdominal pain. Subsequently, the ultrasound helped by confirm the diagnose of aortic aneurysm and also characterized it.

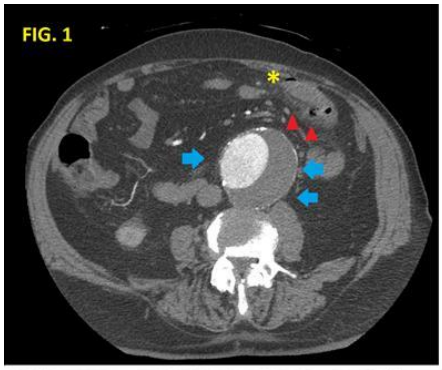
Finally, the tomography, in addition to confirming the presence of the aneurysm andruling out its complications, evidenced the real cause of the abdominal pain: acute perforated jejunal diverticulitis located nearby the aneurysm.

All these findings conditioned the conservative therapeutic behavior used in first instance delaying the vascular intervention once the acute pathology was resolved.

CONCLUSION

The clinical presentation of an acute abdomen in elderly can become very complicated to address, not only because of the multiple pathologies that can be responsible of it but also due to nonspecific clinical information.

Our case demonstrates how the proper use of imaging techniques helped discover the real underlying etiology, based on the importance of being aware on subtle secondary imaging findings that explained better the clinical presentation.



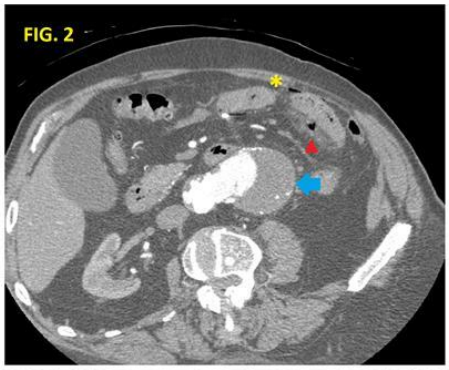
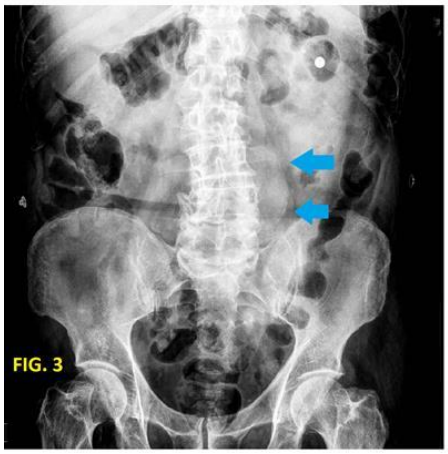


Fig. 1 and 2: CT axial images show jejunal diverticulitis (red arrowhead) and extraluminal air bubbles (yellow *). Also big abdominal aneurysm with a non-complicated mural thrombus is present. (Blue arrows).



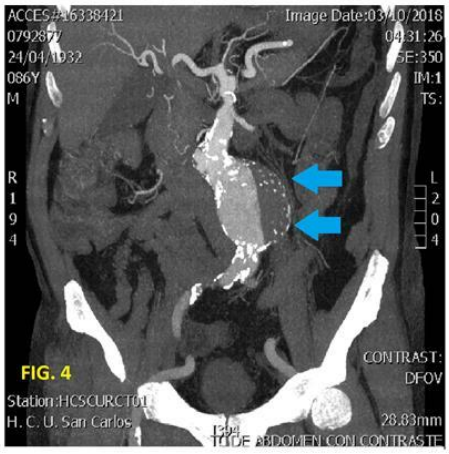


Fig. 3 and 4: Abdominal aneurysm correlation between plain abdominal X-ray film and Coronal CT image (blue arrows).

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