**Name of Journal:** ***World Journal of*** ***Gastroenterology***

**Manuscript NO: 40032**

**Manuscript Type: MINIREVIEWS**

**Diagnosis and management of fibromuscular dysplasia and segmental arterial mediolysis in gastroenterology field: A mini-review**

Ko M *et al*. Fibromuscular dysplasia and segmental arterial mediolysis

Masayoshi Ko, Kenya Kamimura, Kohei Ogawa, Kentaro Tominaga, Akira Sakamaki, Hiroteru Kamimura, Satoshi Abe, Kenichi Mizuno, Shuji Terai

**Masayoshi Ko, Kenya Kamimura, Kohei Ogawa, Kentaro Tominaga, Akira Sakamaki, Hiroteru Kamimura, Satoshi Abe, Kenichi Mizuno, Shuji Terai,** Division of Gastroenterology and Hepatology, Graduate School of Medical and Dental Sciences, Niigata University, Niigata 9518510, Japan

**ORCID number:** Masayoshi Ko (0000-0002-0792-0868); Kenya Kamimura (0000-0001-7182-4400); Kohei Ogawa (0000-0001-6681-4427); Kentaro Tominaga(0000-0001-6792-1005);Akira Sakamaki (0000-0002-9368-7272);Hiroteru Kamimura(0000-0002-9135-3092);Satoshi Abe (0000-0003-1153-0720);Kenichi Mizuno (0000-0003-4702-9874); Shuji Terai (0000-0002-5439-635X).

**Author contributions:** Ko M, Kamimura K wrote the manuscript; Ogawa K, Tominaga K, Sakamaki A, Kamimura H, Abe S, Mizuno K, and Terai S collected information; all authors read and approved the final version of the manuscript.

**Conflict-of-interest statement:** The authors declare that they have no current financial arrangement or affiliation with any organization that may have a direct influence on their work.

**Open-Access:** This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

**Manuscript source:** Invited manuscript

**Correspondence to: Kenya Kamimura, MD, PhD, Lecturer,** Division of Gastroenterology and Hepatology, Graduate School of Medical and Dental Sciences, Niigata University, 1-757 Asahimachi-dori, Chuo-ku, Niigata 9518510, Japan. kenya–k@med.niigata–u.ac.jp

**Telephone**: +81-25-2272207

**Fax**: +81-25-2270776

**Received:** May 25, 2018

**Peer-review started:** May 27, 2018

**First decision:** June 15, 2018

**Revised:** June 17, 2018

**Accepted:** June 25, 2018

**Article in press:**

**Published online:**

**Abstract**

The vascular diseases including aneurysm, occlusion, and thromboses in the mesenteric lesions could cause severe symptoms and appropriate diagnosis and treatment are essential for managing patients. With the development and improvement of imaging modalities, diagnostic frequency of these vascular diseases in abdominal lesions is increasing even with the small changes in the vasculatures. Among various vascular diseases, fibromuscular dysplasia (FMD) and segmental arterial mediolysis (SAM) are noninflammatory, nonatherosclerotic arterial diseases which need to be diagnosed urgently because these diseases could affect various organs and be lethal if the appropriate management is not provided. However, because FMD and SAM are rare, the cause, prevalence, clinical characteristics including the symptoms, findings in the imaging studies, pathological findings, management, and prognoses have not been systematically summarized. Therefore, there have been neither standard diagnostic criteria nor therapeutic methodologies established, to date. To systematically summarize the information and to compare these disease entities, we have summarized the characteristics of FMD and SAM in the gastroenterological regions by reviewing the cases reported thus far. The information summarized will be helpful for physicians treating these patients in an emergency care unit and for the differential diagnosis of other diseases showing severe abdominal pain.

**Key words**: Fibromuscular dysplasia; Segmental arterial mediolysis; Mesenteric lesion; diagnosis; Humans

**© The Author(s) 2018.** Published by Baishideng Publishing Group Inc. All rights reserved.

**Core tip:** The vascular diseases in the abdominal lesions needs to be appropriately diagnosed and treated as it could be lethal if the appropriate management is not provided. Mesenteric ischemia caused by the atherosclerotic changes is rather famous however, fibromuscular dysplasia (FMD) and segmental arterial mediolysis (SAM) which are noninflammatory, nonatherosclerotic arterial diseases are rare and the cause, prevalence, clinical characteristics including the symptoms, findings in the imaging studies, pathological findings, management, and prognoses have not been systematically summarized. Therefore, we have summarized the characteristics of FMD and SAM in the gastroenterological regions and review the cases reported thus far. The information summarized will be helpful for physicians treating these patients in an emergency care unit and for the differential diagnosis of other diseases showing severe abdominal pain.

Ko M, Kamimura K, Ogawa K, Tominaga K, Sakamaki A, Kamimura H, Abe S, Mizuno K, Terai S. Diagnosis and management of fibromuscular dysplasia and segmental arterial mediolysis in gastroenterology field: A mini-review. *World J Gastroenterol* 2018; In press

**INTRODUCTION**

A literature search was conducted using PubMed and Ovid, with the term “fibromuscular dysplasia” or “segmental arterial mediolysis” and “mesenteric” to extract studies published in the last 55 years for fibromuscular dysplasia and in the last 21 years for segmental arterial mediolysis. We summarized the available information on demographics, clinical symptoms, image studies, histological findings, treatment, and clinical course.

**FIBROMUSCULAR DYSPLASIA**

***Clinical characteristics***

The detailed clinical and pathological classification of fibromuscular dysplasia (FMD) was first reported by Harrison and McCormack in 1971[1]. Since then, several studies regarding clinical course and histological data have been published, and recently, data from the first 447 patients from the United States Registry for FMD (US Registry) have been reported1. FMD is a noninflammatory, nonatherosclerotic arterial disease of the medium-sized arteries throughout the body, which could lead to arterial stenosis, occlusion, aneurysm, and dissection[2]. The details of the disease have not yet been clarified; however, it is typically found in the renal, extracranial, carotid, and vertebral arteries[2].

The disease is rare, with a frequency of 0.02%, predominantly occurring in women (91%) with a mean age of 55.7 ± 13.1 years especially in the Caucasian (95.4%)[2].

The mean patient age at first symptom or sign of FMD was 47.2 years (range, 5-83 years)[2]. The mechanisms underlying the pathogenesis of FMD are still poorly understood; however, smoking, hormones, HLA-DRw6 polymorphism, and physiological stimulation have been reported to be risk factors[3]. For example, a significant dose–response relationship between cigarette smoking and the presence of FMD has been reported, with an odds ratio of 8.6 when having smoked more than 10 pack-years of cigarettes[3]. The risk of HLA-DRw6 was reported with an odds ratio of 5.0, adjusted for the level of smoking[3].

FMD can occur in any medium-sized arteries throughout the body, and dissection and aneurysm have been identified in 19.7% and 17.0% of FMD patients, respectively. The three major sites affected with dissection are the carotid arteries (14.8% of all patients enrolled), followed by renal arteries (4.3%), and vertebral arteries (3.4%)[2,4]. The three major sites affected with aneurysm are the renal arteries (5.6% of all patients enrolled), followed by carotid arteries (3.6%), and the aorta (3.4%)[2]. FMD in abdominal lesions, classified as mesenteric FMD, which is caused by the celiac and mesenteric arteries, is a rare condition and often presents as an incidental diagnosis[2]. On the basis of the US Registry data, mesenteric ischemia was reported in only 1.3% of cases, with aneurysm and dissection in these vessels accounting for 6.8% and 22.3% of all cases reported, respectively[2].

***Symptoms and imaging***

The clinical symptoms depend on the vessels involved. When the renal arteries are affected, renovascular hypertension can be observed. Thus, when the carotid arteries are affected, headache, pulsatile tinnitus, and dizziness are the major symptoms[2]. Mesenteric FMD involves the celiac and mesenteric arteries; therefore, mesenteric ischemic symptoms occur, including unspecific abdominal pain. We reviewed the literature describing the cases and have presented the information in Table 1**[**5-37]. Our literature review summarized a total of 39 cases of mesenteric FMD, showing predominance in women, as reported, and the median age was 45.2 years (range: 19-78 years). Regarding the risk factors, four patients smoked (10%), two patients had smoking histories (5%), and one patient had taken oral contraceptive pills (2.6%). The most common presenting symptom was abdominal pain (62%), followed by hypertension, diarrhea, nausea or vomiting, and headache. Although approximately 80% of cases showed symptom improvement, eight patients (20%) died because of the severity of the intestinal ischemia.

Reflecting the changes in stenosis, dissection, and aneurysm in the medium-sized arteries, FMD leads to the narrowing of the vasculature and shows a beaded appearance[38]. Therefore, catheter-based angiography has been considered to be the gold standard imaging modality; however, recent progress in imaging, such as computed tomography (CT) with high resolution, could support the diagnoses by determining the vessels affected by the disease. With the information obtained from imaging, the disease is classified into four types: multifocal, which comprises 62% of cases, showing multiple stenosis and string-of-beads; tubular, which comprises 14% of cases, showing long concentric stenosis; focal, which comprises 7% of cases, showing short stenosis of less than 1 cm; and mixed[39]. Our summary also showed aneurysms, stenosis, dissection, and occlusions in the cases for which information was available.

***Histology***

Histopathological findings are characteristics of the disease; thinned media and thickened fibromuscular ridges in which the arterial muscle is replaced by the fibroplasia can be observed. Based on this, the characteristic classification of FMD is essentially based on the arterial layer in which the dysplasia is predominant: intimal fibroplasia, medial fibroplasia, perimedial fibroplasia, medial hyperplasia, and adventitial fibroplasia[40-43]. Intimal fibroplasia, a relatively rare form of the disease, is characterized by focal eccentric or circumferential protuberant intimal proliferation. Medial fibroplasia, the most common type, accounts for more than 70% of this disorder, and angiography shows a typical “string of beads” appearance. Perimedial fibroplasia is the second-most common form of this disorder and is characterized by the accumulation of circumferential aggregations of elastic tissue between the media and the adventitia. Medial hyperplasia is an uncommon form and is characterized by apparent hyperplasia of normal medial smooth muscle with minimal architectural disorganization. Adventitial fibroplasia is characterized by collagenous fibroplasia encircling the adventitia and extending into the surrounding periarterial fibroadipose tissue[20]. In our case summary, fibromuscular change was confirmed histologically in the medial layer in 10 patients (26%), the intimal layer in 9 patients (23%), in both layers in 5 patients (13%), and in the adventitia layer in 1 patient (2.6%) (Table 1).

***Treatment***

The long-term outcomes of this disease entity have not been clarified to date, and no randomized clinical trials have been conducted to develop a standard treatment for this disease. Therapeutic options have been chosen on the basis of factors such as disease location, symptoms, prior history of symptoms, and the presence and size of aneurysms. Given that FMD often shows ischemic changes causing hypertension and stroke, most patients are treated with anti-platelet, anti-thrombotic, and anti-hypertensive therapy[44]. Anti-hypertensive medications are administered to 71.7% of patients. The median number of medications patients received was one, and 21.5% of patients received three or more anti-hypertensive medications. The most commonly used agents were beta-blockers (40.0%), diuretics (31.3%), and calcium channel antagonists (25.7%). A total of 21.0% of patients received an angiotensin-converting enzyme inhibitor, 21.6% received an angiotensin receptor blocking agent, and 0.8% received both[44]. The use of anti-hypertensive agents is related to the history of hypertension medication, body mass index, and renal function[44]. The use of anti-platelet treatment is associated with cerebrovascular involvement44; however, for this entity of medicines, further studies are necessary to determine the clinically meaningful patient outcomes. In our case summary, insufficient information about medications was provided; thus, the actual number treated with antihypertensive therapy might be lower than 18% (Table 1). Anti-coagulation therapy was attempted for two patients (5%), including one patient each receiving warfarin and aspirin.

Vascular intervention and surgery for revascularization are considered with the appropriate clinical symptoms and are rarely performed other than for the renal artery[44]. For the renal artery, endovascular revascularization using the percutaneous transluminal angioplasty technique or surgical procedures are considered when the patients show hypertension resistant to a regimen of three anti-hypertension drugs, including diuretics, or in cases of renal artery aneurysm or renal artery dissection[2,4,38]. Thus far, no randomized clinical trials of revascularization *vs* medication have been conducted. For other arteries, including the carotid artery, given that FMD is not an atherosclerotic disease, stenting or surgical procedures are not the standard therapy, and medication with anti-platelet, anti-coagulant, and anti-hypertensive agents are the main treatment. However, when symptomatic, interventional radiology using the percutaneous transluminal angioplasty technique can be considered, although it is controversial[38]. In our case summary, open surgery was performed on 23 patients (59%) and endovascular intervention was performed on 9 patients (23%).

***Prognosis***

Though the prognosis is basically good, when FMD affects the cerebrovascular system, there is a risk of cerebral infarction and rupture. A larger number of cases are necessary to accumulate the information useful to conduct randomized clinical trials.

**SEGMENTAL ARTERIAL MEDIOLYSIS**

***Clinical characteristics***

Segmental arterial mediolysis (SAM) was first reported by Slavin and Gonzalez-Vitale in 1976[45] and is a rare disease entity for which 50 cases have been reported to date. It is defined as a nonatherosclerotic, noninflammatory disruption of the arterial medial layer of a medium- to large-sized artery. Histologically, it is characterized as vacuolization and lysis of the outer arterial media[45]. Because of its rarity and difficulty in differential diagnosis from the other vascular diseases, clinical information is insufficient, and little is known to date; however, no significant predominance of sex or age has been reported. The mechanisms underlying the pathogenesis of SAM that have been reported as risk factors are hypoxia, shock, aging, hypertension, circulatory disturbance, arteriospasm, and other vasoconstrictor stimuli[45-47].

***Symptoms and imaging***

For the abdominal lesion, the most common symptom is nonspecific abdominal and flank pain[46]; diarrhea, nausea, back pain, headache, hypertension, loss of consciousness, and hemiparesis have also been known to be symptoms, although not specific[47]. We reviewed the literature describing the cases and have summarized the information in Table 2**[**47-71]. The studies reported a total of 26 cases of mesenteric SAM, of which 17 were men and 9 were women, with a slight predominance in men. The median age was 53 years (range: 25-79 years). The most common presenting symptom was abdominal pain (78%), followed by various symptoms, including shock, diarrhea, nausea, back pain, headache, anorexia, hypertension, hemiparesis, and loss of consciousness (Table 2).

With the development of various imaging modalities, it has been reported that, in various combinations, SAM typically affects splenic, celiac, hepatic, mesenteric, and renal arteries in the abdominal lesion[47,72]. Because of the involvement of the celiac artery, splenic arterial aneurysm is frequently found, and its rupture could affect the prognosis. Angiography reveals aneurysms, dissections, occlusions, and stenosis; however, the findings could overlap with those found in collagen vascular diseases and FMD. Therefore, the differential diagnoses between the vascular diseases are based on the histopathological findings. SAM is difficult to distinguish from FMD, although FMD shows predominance in young women and affects renal arteries causing hypertension, whereas SAM commonly affects the celiac arteries. In addition, the clinical course shows ischemic changes in FMD, whereas SAM often causes profuse bleeding from the intestinal arteries. However, these findings often overlap each other; therefore, accumulation of more detailed information is necessary.

***Histology***

Although the suspicion of SAM is the basis of clinical and radiological features, the gold standard for diagnosis is a pathological finding involving injurious and reparative phases in the arterial lesions of the surgical specimens. These injurious states include mediolysis, separation of the outer media, and formation of arterial gaps; key is that there is no evidence of inflammation. These changes reflect the vascular aneurysms frequently found as angiographic features of this condition. Commonly, the inflammatory markers are negative and genetic diagnosis for collagen vascular disorders shows a normal pattern.

***Treatment***

The long-term prognosis is unclear, and no standard therapeutic strategy has been proposed, to date; however, given that some SAM cases showed sudden the onset of aneurysm rupture, the condition could be life threatening. Therefore, SAM treatment includes embolization, bypass, and resection of the injured arteries. In addition, anti-hypertensive therapy[28] could prevent further worsening of the arterial lesions. Anti-coagulation therapy is uncommon, and only a few cases have been reported to date[59–61]. In addition, given it is a noninflammatory disorder, no evidence of efficacy in use of anti-inflammatory agents or immunosuppressive agents has been reported. However, SAM has been treated with these agents when the differential diagnosis from the other arteritis was difficult[70].

For patients presenting acutely with intra-abdominal hemorrhage, patients are treated with emergent catheter angiography, endovascular intervention, or surgical treatment[73].

Shenouda reported that coil embolization was the most common endovascular intervention and was reported as successful in 88% of patients, with no mortality, whereas the open surgical approach was associated with a 9% mortality rate[72]. In our patient summary, open surgery was most commonly performed, and this was performed on 13 patients (50%). Endovascular intervention was performed on eight patients (31%), and anti-coagulation therapy was administered to two patients (7.7%), including warfarin and aspirin administration. Anti-hypertensive therapy was administered to one patient with Ca-blocker.

***Prognosis***

Although the prognosis of the disease is reported to be good when managed appropriately[72], SAM can be fatal when ruptured[49,73]. Therefore, a careful diagnosis and appropriate management are essential for this disease entity. Our case summary also showed that although 24 (92%) patients improved, 2 (7.7%) patients died, 1 having had a large hematoma and a ruptured aneurysm in the mesenteric lesion that was revealed upon the emergent surgery.

**DISCUSSION**

The inner wall of a normal artery is smooth and in the normal condition, blood flows through it without difficulty. The major cause of decreasing the blood flow is atherosclerosis which is due to the deposits of fatty materials, such as cholesterol, developing the thickened arterial walls and stenosis of the vasculatures. These changes cause ischemic changes in the organs fed by the vasculatures and if it occurred in the abdominal mesenteric lesions, the symptoms of severe abdominal pain, ischemic changes of the intestine could be observed leading to lethality. For other vascular diseases including aneurysm, occlusion, and thromboses in the mesenteric lesions could cause severe symptoms and appropriate diagnosis and treatment are essential for managing patients. With the development and improvement of imaging modalities, including CT and magnetic resonance imaging, the frequency of diagnosis of vascular disease in abdominal lesions is increasing. Among these, FMD and SAM are known as noninflammatory, nonatherosclerotic arterial diseases, difficult to be differentially diagnosed from each other. Although various arteries are involved in these diseases, we have focused on the mesenteric areas, reviewing cases in this study and summarizing the clinical characteristics of both disease entities (Figure 1).

The histologic findings and the imaging findings of FMD and SAM are similar; for example, Lie proposed that SAM can represent a precursor of certain types of FMD. Slavin and colleagues also proposed that SAM could represent a precursor of FMD, although a part of SAM might remain as unspecified aneurysms[46]. Although these similarities in radiological and histological diagnoses have been reported, the two entities exhibit a different clinical profile in terms of age of onset, sex, distribution of affected arteries, and clinical symptoms. Although FMD affects middle-aged women, there is no predilection for age or sex in SAM[2,73].

Considering the mesenteric lesions, as there are no specific symptoms, a greater knowledge and comprehensive understanding of these diseases are important for appropriate diagnosis and treatment. For example, FMD rarely shows significant symptoms and is frequently associated with symptoms of occlusive disease such as renovascular hypertension, headache, and pulsatile tinnitus. Although FMD does not rupture as often, SAM shows hemorrhages resulting from arterial rupture or dissection from the weakened arterial wall[4,46] and is therefore symptomatic with acute abdominal and flank pain.

**CONCLUSION**

Mesenteric vascular diseases are rare compared with other disease entities in lesions; therefore, clinical information is insufficient and clinical trials to develop the standard therapy are lacking. Therefore, an accumulation of cases and a summary of the clinical characteristics of reported cases are important. For this purpose, we have summarized the characteristics of FMD and SAM in abdominal lesions. This information could help physicians to appropriately diagnose and treat cases, including consultation with interventional radiologists and surgeons.

**REFERENCES**

1 **Harrison EG Jr**, McCormack LJ. Pathologic classification of renal arterial disease in renovascular hypertension. *Mayo Clin Proc* 1971; **46**: 161-167 [PMID: 5553126]

2 **Olin JW**, Froehlich J, Gu X, Bacharach JM, Eagle K, Gray BH, Jaff MR, Kim ES, Mace P, Matsumoto AH, McBane RD, Kline-Rogers E, White CJ, Gornik HL. The United States Registry for Fibromuscular Dysplasia: results in the first 447 patients. *Circulation* 2012; **125**: 3182-3190 [PMID: 22615343 DOI: 10.1161/CIRCULATIONAHA.112.091223]

3 **Sang CN**, Whelton PK, Hamper UM, Connolly M, Kadir S, White RI, Sanders R, Liang KY, Bias W. Etiologic factors in renovascular fibromuscular dysplasia. A case-control study. *Hypertension* 1989; **14**: 472-479 [PMID: 2680961]

4 **Olin JW**, Gornik HL, Bacharach JM, Biller J, Fine LJ, Gray BH, Gray WA, Gupta R, Hamburg NM, Katzen BT, Lookstein RA, Lumsden AB, Newburger JW, Rundek T, Sperati CJ, Stanley JC; American Heart Association Council on Peripheral Vascular Disease; American Heart Association Council on Clinical Cardiology; American Heart Association Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation; American Heart Association Council on Cardiovascular Disease in the Young; American Heart Association Council on Cardiovascular Radiology and Intervention; American Heart Association Council on Epidemiology and Prevention; American Heart Association Council on Functional Genomics and Translational Biology; American Heart Association Council for High Blood Pressure Research; American Heart Association Council on the Kidney in Cardiovascular Disease; American Heart Association Stroke Council. Fibromuscular dysplasia: state of the science and critical unanswered questions: a scientific statement from the American Heart Association. *Circulation* 2014; **129**: 1048-1078 [PMID: 24548843 DOI: 10.1161/01.cir.0000442577.96802.8c]

5 **ABOUMRAD MH**, FINE G, HORN RC Jr. Intimal hyperplasia of small mesenteric arteries. Occlusive, with infarction of the intestine. *Arch Pathol* 1963; **75**: 196-200 [PMID: 14010713]

6 **Ripley HR**, Levin SM. Abdominal angina associated with fibromuscular hyperplasia of the celiac and superior mesenteric arteries. *Angiology* 1966; **17**: 297-310 [PMID: 5936946 DOI: 10.1177/000331976601700506]

7 **Wylie EJ**, Binkley FM, Palubinskas AJ. Extrarenal fibromuscular hyperplasia. *Am J Surg* 1966; **112**: 149-155 [PMID: 5911218]

8 **Claiborne TS**. Fibromuscular hyperplasia. Report of a case with involvement of multiple arteries. *Am J Med* 1970; **49**: 103-105 [PMID: 5431471]

9 **Lie JT**, Kim HS. Fibromuscular dysplasia of the superior mesenteric artery and coexisting cerebral berry aneurysms. *Angiology* 1977; **28**: 256-260 [PMID: 869283 DOI: 10.1177/000331977702800405]

10 **Rybka SJ**, Novick AC. Concomitant carotid, mesenteric and renal artery stenosis due to primary intimal fibroplasia. *J Urol* 1983; **129**: 798-800 [PMID: 6842706]

11 **Foissy P**, Fabre M, Lebaleur A, Buffet C, Frileux C, Etienne JP. [Aneurysm of the trunk of the superior mesenteric artery and polyaneurysmal disease of the right paracolic arcade of fibromuscular hyperplasia type. A case]. *Ann Med Interne* (Paris) 1984; **135**: 530-532 [PMID: 6517425]

12 **den Butter G**, van Bockel JH, Aarts JC. Arterial fibrodysplasia: rapid progression complicated by rupture of a visceral aneurysm into the gastrointestinal tract. *J Vasc Surg* 1988; **7**: 449-453 [PMID: 3258042]

13 **Salmon PJ**, Allan JS. An unusual case of fibromuscular dysplasia. *J Cardiovasc Surg* (Torino) 1988; **29**: 756-757 [PMID: 3209621]

14 **Insall RL**, Chamberlain J, Loose HW. Fibromuscular dysplasia of visceral arteries. *Eur J Vasc Surg* 1992; **6**: 668-672 [PMID: 1451828]

15 . Case records of the Massachusetts General Hospital. Weekly clinicopathological exercises. Case 9-1995. A 60-year-old man with hypertrophic cardiomyopathy and ischemic colitis. *N Engl J Med* 1995; **332**: 804-810 [PMID: 7862185 DOI: 10.1056/NEJM199503233321208]

16 **Stokes JB**, Bonsib SM, McBride JW. Diffuse intimal fibromuscular dysplasia with multiorgan failure. *Arch Intern Med* 1996; **156**: 2611-2614 [PMID: 8951305]

17 **Yamaguchi R**, Yamaguchi A, Isogai M, Hori A, Kin Y. Fibromuscular dysplasia of the visceral arteries. *Am J Gastroenterol* 1996; **91**: 1635-1638 [PMID: 8759676]

18 **Lee EK**, Hecht ST, Lie JT. Multiple intracranial and systemic aneurysms associated with infantile-onset arterial fibromuscular dysplasia. *Neurology* 1998; **50**: 828-829 [PMID: 9521295]

19 **Safioleas M**, Kakisis J, Manti C. Coexistence of hypertrophic cardiomyopathy and fibromuscular dysplasia of the superior mesenteric artery. *N Engl J Med* 2001; **344**: 1333-1334 [PMID: 11336027 DOI: 10.1056/NEJM200104263441716]

20 **Horie T**, Seino Y, Miyauchi Y, Saitoh T, Takano T, Ohashi A, Yamada N, Tamura K, Yamanaka N. Unusual petal-like fibromuscular dysplasia as a cause of acute abdomen and circulatory shock. *Jpn Heart J* 2002; **43**: 301-305 [PMID: 12227706]

21 **Kojima A**, Shindo S, Kubota K, Iyori K, Ishimoto T, Kobayashi M, Tada Y. Successful surgical treatment of a patient with multiple visceral artery aneurysms due to fibromuscular dysplasia. *Cardiovasc Surg* 2002; **10**: 157-160 [PMID: 11888746]

22 **Felton TW**, Drewe E, Jivan S, Hall RI, Powell RJ. A rare case of shock. *Ann Rheum Dis* 2003; **62**: 705-706 [PMID: 12860723]

23 **Guill CK**, Benavides DC, Rees C, Fenves AZ, Burton EC. Fatal mesenteric fibromuscular dysplasia: a case report and review of the literature. *Arch Intern Med* 2004; **164**: 1148-1153 [PMID: 15159274 DOI: 10.1001/archinte.164.10.1148]

24 **Mertens J**, Daenens K, Fourneau I, Marakbi A, Nevelsteen A. Fibromuscular dysplasia of the superior mesenteric artery--case report and review of the literature. *Acta Chir Belg* 2005; **105**: 523-527 [PMID: 16315839]

25 **Rodriguez Urrego PA**, Flanagan M, Tsai WS, Rezac C, Barnard N. Massive gastrointestinal bleeding: an unusual case of asymptomatic extrarenal, visceral, fibromuscular dysplasia. *World J Gastroenterol* 2007; **13**: 5771-5774 [PMID: 17963307]

26 **Chaturvedi R**, Vaideeswar P, Joshi A, Pandit S. Unusual mesenteric fibromuscular dysplasia a rare cause for chronic intestinal ischaemia. *J Clin Pathol* 2008; **61**: 237 [PMID: 18223099 DOI: 10.1136/jcp.2007.049569]

27 **Malagò R**, D'Onofrio M, Mucelli RP. Fibromuscular dysplasia: noninvasive evaluation of unusual case of renal and mesenteric involvement. *Urology* 2008; **71**: 755.e13-755.e15 [PMID: 18313108 DOI: 10.1016/j.urology.2007.10.061]

28 **Veraldi GF**, Zecchinelli MP, Furlan F, Genco B, Minicozzi AM, Segattini C, Pacca R. Mesenteric revascularisation in a young patient with antiphospholipid syndrome and fibromuscular dysplasia: report of a case and review of the literature. *Chir Ital* 2009; **61**: 659-665 [PMID: 20380275]

29 **Kimura K**, Ohtake H, Kato H, Yashiki N, Tomita S, Watanabe G. Multivisceral fibromuscular dysplasia: an unusual case of renal and superior mesenteric involvement. *Ann Vasc Dis* 2010; **3**: 152-156 [PMID: 23555404 DOI: 10.3400/avd.AVDcr01017]

30 **Senadhi V**. A rare cause of chronic mesenteric ischemia from fibromuscular dysplasia: a case report. *J Med Case Rep* 2010; **4**: 373 [PMID: 21092091 DOI: 10.1186/1752-1947-4-373]

31 **Sugiura T**, Imoto K, Uchida K, Yanagi H, Machida D, Okiyama M, Yasuda S, Takebayashi S. Fibromuscular dysplasia associated with simultaneous spontaneous dissection of four peripheral arteries in a 30-year-old man. *Ann Vasc Surg* 2011; **25**: 838.e9-838.11 [PMID: 21616635 DOI: 10.1016/j.avsg.2011.02.018]

32 **Dolak W**, Maresch J, Kainberger F, Wrba F, Müller Ch. Fibromuscular dysplasia mimicking Crohn's disease over a period of 23 years. *J Crohns Colitis* 2012; **6**: 354-357 [PMID: 22405173 DOI: 10.1016/j.crohns.2011.09.012]

33 **Patel NC**, Palmer WC, Gill KR, Wallace MB. A case of mesenteric ischemia secondary to Fibromuscular Dysplasia (FMD) with a positive outcome after intervention. *J Interv Gastroenterol* 2012; **2**: 199-201 [PMID: 23687610 DOI: 10.4161/jig.23747]

34 **Sekar N**, Shankar R. Fibromuscular dysplasia with multiple visceral artery involvement. *J Vasc Surg* 2013; **57**: 1401 [PMID: 23601593 DOI: 10.1016/j.jvs.2011.12.079]

35 **Mitchell A**, Caty V, Bendavid Y. Massive mesenteric panniculitis due to fibromuscular dysplasia of the inferior mesenteric artery: a case report. *BMC Gastroenterol* 2015; **15**: 71 [PMID: 26100669 DOI: 10.1186/s12876-015-0303-5]

36 **Yamada M**, Nakada TA, Idoguchi K, Matsuoka T. Fibromuscular dysplasia presenting as hemorrhagic shock due to spontaneous rupture of a right gastroepiploic artery aneurysm. *Am J Emerg Med* 2016; **34**: 677.e3-677.e5 [PMID: 26166380 DOI: 10.1016/j.ajem.2015.06.054]

37 **Erwin PA**, Blas JV, Gandhi S, Romero ME, Gray BH. Images in Vascular Medicine. Visceral fibromuscular dysplasia in a patient with chronic abdominal pain. *Vasc Med* 2016; **21**: 170-171 [PMID: 26675330 DOI: 10.1177/1358863X15619242]

38 **Brinza EK**, Gornik HL. Fibromuscular dysplasia: Advances in understanding and management. *Cleve Clin J Med* 2016; **83**: S45-S51 [PMID: 27861117 DOI: 10.3949/ccjm.83.s2.06]

39 **Kincaid OW**, Davis GD, Hallermann FJ, Hunt JC. Fibromuscular dysplasia of the renal arteries. Arteriographic features, classification, and observations on natural history of the disease. *Am J Roentgenol Radium Ther Nucl Med* 1968; **104**: 271-282 [PMID: 5685786]

40 **Lüscher TF**, Lie JT, Stanson AW, Houser OW, Hollier LH, Sheps SG. Arterial fibromuscular dysplasia. *Mayo Clin Proc* 1987; **62**: 931-952 [PMID: 3309488]

41 **Alimi Y**, Mercier C, Péllissier JF, Piquet P, Tournigand P. Fibromuscular disease of the renal artery: a new histopathologic classification. *Ann Vasc Surg* 1992; **6**: 220-224 [PMID: 1610652 DOI: 10.1007/BF02000266]

42 **Mettinger KL**, Ericson K. Fibromuscular dysplasia and the brain. I. Observations on angiographic, clinical and genetic characteristics. *Stroke* 1982; **13**: 46-52 [PMID: 7064180]

43 **Mettinger KL**. Fibromuscular dysplasia and the brain. II. Current concept of the disease. *Stroke* 1982; **13**: 53-58 [PMID: 7039003]

44 **Weinberg I**, Gu X, Giri J, Kim SE, Bacharach MJ, Gray BH, Katzen BT, Matsumoto AH, Chi YW, Rogers KR, Froehlich J, Olin JW, Gornik HL, Jaff MR. Anti-platelet and anti-hypertension medication use in patients with fibromuscular dysplasia: Results from the United States Registry for Fibromuscular Dysplasia. *Vasc Med* 2015; **20**: 447-453 [PMID: 25964292 DOI: 10.1177/1358863X15584982]

45 **Slavin RE**, Gonzalez-Vitale JC. Segmental mediolytic arteritis: a clinical pathologic study. *Lab Invest* 1976; **35**: 23-29 [PMID: 940319]

46 **Slavin RE**, Saeki K, Bhagavan B, Maas AE. Segmental arterial mediolysis: a precursor to fibromuscular dysplasia? *Mod Pathol* 1995; **8**: 287-294 [PMID: 7617656]

47 **Baker-LePain JC**, Stone DH, Mattis AN, Nakamura MC, Fye KH. Clinical diagnosis of segmental arterial mediolysis: differentiation from vasculitis and other mimics. *Arthritis Care Res* (Hoboken) 2010; **62**: 1655-1660 [PMID: 20662047 DOI: 10.1002/acr.20294]

48 **Sakano T**, Morita K, Imaki M, Ueno H. Segmental arterial mediolysis studied by repeated angiography. *Br J Rad* 1997; **70**: 656-658

49 **Rengstorff DS**, Baker EL, Wack J, Yee LF. Intra-abdominal hemorrhage caused by segmental arterial mediolysis of the inferior mesenteric artery: report of a case. *Dis Colon Rectum* 2004; **47**: 769-772 [PMID: 15054678 DOI: 10.1007/s10350-003-0103-9]

50 **Chino O**, Kijima H, Shibuya M, Yamamoto S, Kashiwagi H, Kondo Y, Makuuchi H. A case report: spontaneous rupture of dissecting aneurysm of the middle colic artery. *Tokai J Exp Clin Med* 2004; **29**: 155-158 [PMID: 15717485]

51 **Basso MC**, Flores PC, de Azevedo Marques A, de Souza GL, D'Elboux Guimarães Brescia M, Campos CR, de Cleva R, Saldiva PH, Mauad T. Bilateral extensive cerebral infarction and mesenteric ischemia associated with segmental arterial mediolysis in two young women. *Pathol Int* 2005; **55**: 632-638 [PMID: 16185293 DOI: 10.1111/j.1440-1827.2005.01881.x]

52 **Obara H**, Matsumoto K, Narimatsu Y, Sugiura H, Kitajima M, Kakefuda T. Reconstructive surgery for segmental arterial mediolysis involving both the internal carotid artery and visceral arteries. *J Vasc Surg* 2006; **43**: 623-626 [PMID: 16520184 DOI: 10.1016/j.jvs.2005.11.033]

53 **Abdelrazeq AS**, Saleem TB, Nejim A, Leveson SH. Massive hemoperitoneum caused by rupture of an aneurysm of the marginal artery of Drummond. *Cardiovasc Intervent Radiol* 2008; **31** Suppl 2: S108-S110 [PMID: 17710481 DOI: 10.1007/s00270-007-9117-3]

54 **Shimohira M**, Ogino H, Sasaki S, Ishikawa K, Koyama M, Watanabe K, Shibamoto Y. Transcatheter arterial embolization for segmental arterial mediolysis. *J Endovasc Ther* 2008; **15**: 493-497 [PMID: 18729557 DOI: 10.1583/08-2384.1]

55 **Hashimoto T**, Deguchi J, Endo H, Miyata T. Successful treatment tailored to each splanchnic arterial lesion due to segmental arterial mediolysis (SAM): report of a case. *J Vasc Surg* 2008; **48**: 1338-1341 [PMID: 18971044 DOI: 10.1016/j.jvs.2008.05.056]

56 **Hirokawa T**, Sawai H, Yamada K, Wakasugi T, Takeyama H, Ogino H, Tsurusaki M, Arai Y. Middle-colic artery aneurysm associated with segmental arterial mediolysis, successfully managed by transcatheter arterial embolization: report of a case. *Surg Today* 2009; **39**: 144-147 [PMID: 19198994 DOI: 10.1007/s00595-008-3811-x]

57 **Fujiwara Y**, Takemura M, Yoshida K, Morimura K, Inoue T. Surgical resection for ruptured aneurysm of middle colic artery caused by segmental arterial mediolysis: a case report. *Osaka City Med J* 2010; **56**: 47-52 [PMID: 21466129]

58 **Obara H**, Matsubara K, Inoue M, Nakatsuka S, Kuribayashi S, Kitagawa Y. Successful endovascular treatment of hemosuccus pancreaticus due to splenic artery aneurysm associated with segmental arterial mediolysis. *J Vasc Surg* 2011; **54**: 1488-1491 [PMID: 21715127 DOI: 10.1016/j.jvs.2011.04.053]

59 **Tameo MN**, Dougherty MJ, Calligaro KD. Spontaneous dissection with rupture of the superior mesenteric artery from segmental arterial mediolysis. *J Vasc Surg* 2011; **53**: 1107-1112 [PMID: 21276678 DOI: 10.1016/j.jvs.2010.11.034]

60 **Filippone EJ**, Foy A, Galanis T, Pokuah M, Newman E, Lallas CD, Gonsalves CF, Farber JL. Segmental arterial mediolysis: report of 2 cases and review of the literature. *Am J Kidney Dis* 2011; **58**: 981-987 [PMID: 21872379 DOI: 10.1053/j.ajkd.2011.05.031]

61 **Taira S**, Katori H, Matsuda Y, Tani I. [Case report: a case of segmental arterial mediolysis (SAM) with bilateral renal infarction, superior mesenteric aneurysm and splenic aneurysm]. *Nihon Naika Gakkai Zasshi* 2011; **100**: 1966-1968 [PMID: 21863772]

62 **Yoo BR**, Han HY, Cho YK, Park SJ. Spontaneous rupture of a middle colic artery aneurysm arising from superior mesenteric artery dissection: Diagnosis by color Doppler ultrasonography and CT angiography. *J Clin Ultrasound* 2012; **40**: 255-259 [PMID: 22457222 DOI: 10.1002/jcu.21906]

63 **Horsley-Silva JL**, Ngamruengphong S, Frey GT, Paz-Fumagalli R, Lewis MD. Segmental arterial mediolysis: a case of mistaken hemorrhagic pancreatitis and review of the literature. *JOP* 2014; **15**: 72-77 [PMID: 24413790]

64 **Gulati G**, Ware A. Segmental arterial mediolysis: a rare non-inflammatory cause of mesenteric bleeding. *BMJ Case Rep* 2015; **2015**: [PMID: 26135493 DOI: 10.1136/bcr-2015-210344]

65 **Fujinaga J**, Kuriyama A. Segmental Arterial Mediolysis. *J Emerg Med* 2016; **51**: 732-733 [PMID: 27670290 DOI: 10.1016/j.jemermed.2016.07.090]

66 **Shinoda N**, Hirai O, Mikami K, Bando T, Shimo D, Kuroyama T, Matsumoto M, Itoh T, Kuramoto Y, Ueno Y. Segmental Arterial Mediolysis Involving Both Vertebral and Middle Colic Arteries Leading to Subarachnoid and Intraperitoneal Hemorrhage. *World Neurosurg* 2016; **88**: 694.e5-694.10 [PMID: 26724638 DOI: 10.1016/j.wneu.2015.12.058]

67 **Galketiya K**, Llewellyn H, Liang X. Spontaneous haemoperitoneum due to segmental arterial mediolysis and rupture of the left colic artery. *ANZ J Surg* 2016; **86**: 201-202 [PMID: 24801961 DOI: 10.1111/ans.12654]

68 **Kuriyama A**. Segmental arterial mediolysis. *Am J Emerg Med* 2017; **35**: 518.e1-518.e2 [PMID: 27742517 DOI: 10.1016/j.ajem.2016.09.036]

69 **Yoshioka T**, Araki M, Ariyoshi Y, Wada K, Tanaka N, Nasu Y. Successful microscopic renal autotransplantation for left renal aneurysm associated with segmental arterial mediolysis. *J Vasc Surg* 2017; **66**: 261-264 [PMID: 27988157 DOI: 10.1016/j.jvs.2016.09.039]

70 **Japikse RD**, Sevenson JE, Pickhardt PJ, Repplinger MD. Segmental Arterial Mediolysis: An Unusual Case Mistaken to be a Strangulated Hernia. *WMJ* 2017; **116**: 173-176 [PMID: 29323836]

71 **Akuzawa N**, Kurabayashi M, Suzuki T, Yoshinari D, Kobayashi M, Tanahashi Y, Makita F, Saito R. Spontaneous isolated dissection of the superior mesenteric artery and aneurysm formation resulting from segmental arterial mediolysis: a case report. *Diagn Pathol* 2017; **12**: 74 [PMID: 29037200 DOI: 10.1186/s13000-017-0664-x]

72 **Shenouda M**, Riga C, Naji Y, Renton S. Segmental arterial mediolysis: a systematic review of 85 cases. *Ann Vasc Surg* 2014; **28**: 269-277 [PMID: 23988553 DOI: 10.1016/j.avsg.2013.03.003]

73 **Pillai AK**, Iqbal SI, Liu RW, Rachamreddy N, Kalva SP. Segmental arterial mediolysis. *Cardiovasc Intervent Radiol* 2014; **37**: 604-612 [PMID: 24554198 DOI: 10.1007/s00270-014-0859-4]

74 **Lie JT**. Segmental mediolytic arteritis: not an arteritis but a variant of arterial fibromuscular dysplasia. *Arch Pathol Lab Med* 1992; **116**: 238-241[PMID: 1536608].

**P-Reviewer:** M’Koma AE **S-Editor:** Wang XJ

**L-Editor:** **E-Editor:**

**Specialty type:** Gastroenterology and hepatology

**Country of origin:** Japan

**Peer-review report classification**

Grade A (Excellent): 0

Grade B (Very good): B

Grade C (Good): 0

Grade D (Fair): 0

Grade E (Poor): 0



**Figure 1 Clinical characteristic of the fibromuscular dysplasia and segmental arterial mediolysis.**

**Table 1 Summary of mesenteric fibromuscular dysplasia reported to date**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case (*n*)** | **Ref.** | **Age (yr)** | **Gender****(Male/Female)** | **Risk factors** | **Symptoms** | **Vessels Involved** | **CT** | **Angiography** | **Pathology** | **Treatment** | **Anti-hypertensive drug** | **Anti-coagulants** | **Outcome** |
|
| 1 | 5 | 62 | M | N/A | Upper abdominal pain, hemoperitoneum, shock | Celiac, SMA, IMA, RA | N/A | N/A | Intimal thickening in the branches of the SMA and IMA. | Laparotomy | − | None | Died |
| 2 | 6 | 45 | F | N/A | Abdominal pain | SMA, RA | N/A | N/A | N/A | Ileal resection | N/A | N/A | Improved |
| 3 | 6 | 50 | F | N/A | Hypertension, abdominal pain, diarrhea | SMA, RA, iliac | N/A | Stenosis and string-of-beads like Appearance in the SMA | N/A | SMA revascularization | N/A | N/A | Improved |
| 4 | 7 | 73 | F | N/A | N/A | Celiac, SMA, iliac | N/A | N/A | N/A | N/A | N/A | N/A | Improved |
| 5 | 7 | 42 | F | N/A | N/A | SMA, RA | N/A | N/A | N/A | N/A | N/A | N/A | Improved |
| 6 | 7 | 50 | F | N/A | Hypertension | Celiac, SMA, RAl | N/A | Minimal defects in the SMA and RA; stenosis of celiac artery | N/A | N/A | N/A | N/A | Improved |
| 7 | 7 | 37 | F | N/A | Visceral ischemic symptoms | Celiac, SMA, RA | N/A | N/A | N/A | Revascularization | N/A | N/A | Improved |
| 8 | 7 | 47 | F | N/A | Hypertension, abdominal pain | Celiac, SMA, RA | N/A | Defects in the SMA and RA | Medial hyperplasia | None | N/A | N/A | Died |
| 9 | 8 | 41 | F | N/A | Hypertension | SMA, internal carotid, RA, iliac | N/A | Corkscrew and string-of-beads like appearance in the RA, carotid, iliac artery | Replacement of the normal media with disorganized fibrous and muscular hyperplasia | Thromboendarerectomy on SMA | N/A | N/A | Died |
| 10 | 9 | 64 | F | N/A | Unconsciousness | SMA, circle of Willis | N/A | N/A | Medial hyperplasia | None | − | None | Died |
| 11 | 10 | 21 | M | N/A | Hypertension | Celiac, SMA, RA, carotid | N/A | Stenosis of celiac, SMA, RA | Intimal fibroplasia | Anti-hypertensive drug; revascularization of carotid artery; angioplasty of RA | Yes, N/A | N/A | Improved |
| 12 | 10 | 20 | F | N/A | Hypertension | SMA, IMA, RA, carotid | N/A | Stenosis of carotid, renal, SMA. Total occlusion of the IMA. | Intimal fibroplasia | Anti-hypertensive drug, subclavian-carotid bypass; vascular reconstruction of the kidney | Yes, N/A | N/A | Improved |
| 13 | 11 | 55 | M | N/A | N/A | SMA | N/A | N/A | Intimal hyperplasia in SMA | None | N/A | N/A | N/A |
| 14 | 12 | 44 | F | N/A | Asymptomatic bruit of the aortoiliac system | Celiac, SMA, RA, iliac | N/A | String-of-beads like appearance of iliac artery; aneurysms of SMA, RA | Intimal fibrosis with development of fibrosis | Resection and reconstruction | N/A | N/A | Improved |
| 15 | 13 | 58 | F | N/A | Body weight loss | Celiac, SMA, IMA, RA, iliac, aorta | N/A | Occlusion of celiac, SMA, IMA. | N/A | Open surgery | N/A | N/A | Improved |
| 16 | 14 | 46 | F | None (non-smoker) | Palpitations, headache, hypertension | Celiac, SMA | N/A | Aneurysms in the right RA, celiac; occlusion in the left gastric artery | Muscle hypertrophy and disorganisation of elastic tissue of the media in celiac artery. | Surgical ligation | N/A | N/A | Improved |
| 17 | 15 | 60 | M | None (non-smoker) | Left abdominal pain, diarrhea | SMA | Irregular nodular thickening in transverse colon. | Stenoses of the SMA | Intimal fibrosis and focal replacement of medial smooth-muscle fibers by fibrous tissue . | Splenic flexure resection and angioplasty | N/A | N/A | Improved |
| 18 | 16 | 54 | F | Smoking | Hypertension, headache, abdominal pain | SMA, RA, coronary | Liver cyst | Stenosis of the coronary arteries | Intimal hyperplasia in SMA, RA, coronary, splenic, intrahepatic artery | Anti-hypertensive drug | α,β-blocker → Ca blocker | N/A | Died |
| 19 | 17 | 39 | M | N/A | Melena, lower abdominal pain | Jejunal, Sigmoid | N/A | String-of-beads like appearance in the jejunal and sigmoid arteries. | Adventitia is thickened by fibroplasia | Resection of the jejunum | N/A | N/A | Improved |
| 20 | 18 | 23 | M | N/A | Hypertension | Celiac, SMA, RA, carotid, vertebral, opthalmic, superficial temporal, iliac, lumber, intercostal | Hematomasin the paraduodenal and right superior gluteral lesin and splenic infarction | Multiple saccular aneurysms in the celiac, SMA, RA< splenic, hepatic, iliac, lumber, and intercostal arteries | Mediolytic FMD with segmental dissection and thrombosis | Embolization of the gastroduodenal and right SMA to prevent hemorrhage | N/A | N/A | Improved |
| 21 | 19 | 33 | M | N/A | Abdominal pain | SMA | N/A | String-of-beads like appearance in the SMA | Thickening of the media due to hyperplasia in SMA | Ileal resection | N/A | N/A | Improved |
| 22 | 20 | 78 | F | N/A | Hypertension, abdominal pain, hemoperitoneum. | SMA, RA, colonary | Dilated loop of the small bowel and fluid in the peritoneal cavity. | N/A | Medial and perimedial fibrodysplasia, forms the characteristic petal-like appearance in SMA. | None | None | None | Died |
| 23 | 21 | 43 | M | None (non-smoker) | No symptoms | SMA, iliac | SMA aneurysm | Aneurysms in the SMA, hepatic artery, splenic artery, jejunal artery, iliac arteries. | Medial fibrodysplasia in the arteral walls | Aneurysm resection and arterial reconstruction | N/A | N/A | Improved |
| 24 | 22 | 48 | F | None (non-smoker) | Abdominal pain, hemoperitoneum | Celiac, SMA, RA | N/A | Multiple small aneurysms in celiac, SMA, RA | N/A | Surgical hemostasis and anti-hypertensive drugs | β-blocker | N/A | Improved |
| 25 | 23 | 57 | F | Smoking (40vpacks/yr) | Abdominal pain, weight loss, anorexia, nausea, vomiting, diarrhea. | Celiac, SMA | Nothing particular | Stenosis of the celiac artery and SMA | Medial thickening, smooth muscle hyperplasia in SMA and celiac artery | Aortoiliac and aorto-SMA bypass | N/A | N/A | Died |
| 26 | 24 | 48 | F | Smoking (20 packs/yr) | Abdominal pain | Celiac, SMA, IMA | N/A | Occlusion of the celiac, SMA; enlarged hypertrophic IMA | Intimal fibroplasia and an increased deposition of fibrous tissue in the vessel wall media | Reimplantation of the SMA | N/A | N/A | Improved |
| 27 | 25 | 38 | M | Smoking | Gastrointestinal bleeding, anemia | SMA, IMA | N/A | Ectasia in IMA; string-of-beads like appearance in the SMA | Thickening and hyalinization of medium sized vessel walls, with intimal proliferation. | Ileal resection | N/A | N/A | Improved |
| 28 | 26 | not provided | not provided | None (non-smoker) | Abdominal pain, distension, constipation | SMA | N/A | N/A | Thick cuff (petal like) of smooth muscle proliferation with normal intima and media in mesenteric artery. | Right hemicolectomy | N/A | N/A | Improved |
| 29 | 27 | 43 | F | Smoking (10 cigarettes daily) for 20 yr | Hypertension, headache | SMA, RA | N/A | String-of-beads like appearance in the right RA and SMA; stenosis and multiple irregularities in the left RA | N/A | Angioplasty and anti-hypertensive drugs | Yes, N/A | N/A | Improved |
| 30 | 28 | 38 | M | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Improved |
| 31 | 29 | 43 | F | N/A | Hypertension, abdominal pain, headache | SMA, RA | Aneurysms in the left RA | Aneurysms in the left RA with sever fibrodysplastic stenosis; string-of-beads like appearance in the right RA; stenosis in SMA | Intimal fibroplasia, lost of internal elastic lamina, and massive destruction of the media in the aneurysm walls | Aneurysm resection and aortorenal bypass and percutaneous transluminal angioplasty | N/A | N/A | Improved |
| 32 | 30 | 44 | F | Oral contraceptive pills | Hypertension, abdominal pain, diarrhea, vomiting | SMA | Stenosis of SMA and nonspecific colitis | stenosis in SMA | N/A | Angioplasty | N/A | N/A | Improved |
| 33 | 31 | 30 | M | N/A | Abdominal pain, hypertension | Celiac, SMA, RA, iliac | Dissections of the celiac, SMA, left RA, and external iliac artery | stenosis in the right RA | N/A | Anti-platelet and anti-hypertensive therapy and angioplasty for right renal artery. | β-blocker, Ca blocker | warfarin, aspirin (100mg) | Improved |
| 34 | 32 | 47 | F | N/A | Abdominal pain, diarrhea, hypertension | All abdominal arteries | A partial occlusion of the celiac artery and a total occlusion of the SMA | N/A | Intimal and medial proliferation | Anti-hypertensive drug | Yes, N/A | N/A | Died |
| 35 | 33 | 47 | F | None (non-smoker) | Nausea, early satiety, abdominal pain | Celiac, SMA | N/A | Stenosis of the SMA, hypertrophy of the gastroduodenal artery and pancreaticoduodenal arteries | N/A | An aorto-superior mesenteric artery and an aorto-hepatic artery bypass. | N/A | N/A | Improved |
| 36 | 34 | 19 | F | N/A | Abdominal pain, vomiting | SMA, RA | N/A | Stenosis of the origin of the SMA and multiple aneurysms involving the proximal SMA. Right renal artery is mild irregularity. | N/A | Resection of the aneurysmal segment in the SMA; aorto-SMA interposition graft with polytetrafluoroethylene | N/A | N/A | Improved |
| 37 | 35 | 52 | M | Smoking | Abdominal pain | IMA | Stenosis of the IMA | N/A | Necrosis of the mucosa; fibrosis of the inima | Left hemicolectomy | N/A | N/A | Improved |
| 38 | 36 | 20 | F | N/A | Abdominal pain, hemorrhagic shock | SMA, right gastroepiploic, jejunal | Intraperitoneal bleeding in the omental bursa and mesentery of the transverse colon | String-of-beads like appearance in the jejunal artery | N/A | Transcatheter arterial embolization | N/A | N/A | Improved |
| 39 | 37 | 61 | F | N/A | Abdominal pain | SMA, IMA, RA | N/A | Multiple aneurysms and stenoses in SMA, IMA, RA | Multiple tears and dissections of the medial layer and fibrointimal thickening | Anti-coagulation | None | Yes, N/A | Improved |

M: Male; F: Female; N/A: Data not applicable; SMA: Superior mesenteric artery; IMA: Inferior mesenteric artery; RA: Renal artery; CT: Computed tomography.

**Table 2 Summary of mesenteric segmental arterial mediolysis reported to date**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case (*n*)** | **Ref.** | **Age (yr)** | **Gender (Male/Female)** | **Risk factors** | **Symptoms** | **Vessels Involved** | **CT** | **Angiography** | **Pathology** | **Treatment** | **Anti-hypertensive drug** | **Anti-coagulants** | **Outcome** |
| 1 | 48 | 65 | F | N/A | Abdominal pain | SMA | N/A | Beaded appearance and stenosis of the MCA | Lysis and destruction in the media and intima | Resection of aneurysm in MCA | N/A | N/A | Improved |
| 2 | 49 | 56 | F | N/A | Abdominal pain | IMA | Intraabdominal hemorrhage | Aneurysm in IMA | N/A | Left hemicolectomy | N/A | N/A | Improved |
| 3 | 50 | 78 | M | N/A | Abdominal pain, diarrhea, shock | SMA | N/A | N/A | Destruction of the tunica interna and media in MCA | Emergent surgery (right hemicolectomy); a large hematoma and a ruptured aneurysm upon the surgery | N/A | N/A | Improved |
| 4 | 51 | 35 | F | N/A | Abdominal pain, perforation on transverse colon | SMA | Occlusion of the mesenteric vein and ischemic colitis | Unremarkable | Segmental vacuolar degeneration of smooth muscle with areas of wall thinning | Resection of termnal ileum | N/A | N/A | Died |
| 5 | 52 | 52 | M | N/A | Sudden hemiparesis, hypertension | Celiac, SMA, IMA hepatic artery | Aneurysm in the celiac, hepatic, SMA | Aneurysms in celiac, SMA, ICA, hepatic; stenoses in cliac and SMA | Multiple segmental mediolysis lesions of the muscular and elastic fibers of the media | Reconstruction of hepatic and celiac artery using autologous saphenous vein graft | N/A | N/A | Improved |
| 6 | 53 | 49 | M | N/A | Abdominal pain, shock | SMA | Large hematoma surrounding a high-density aneurysm | Beaded appearance in SMA | Multifocal fragmentation of the elastic fibers of the media | Right hemicolectomy | N/A | N/A | Improved |
| 7 | 54 | 57 | M | N/A | Abdominal pain | SMA, hepatic | Small aneurysm at the middle colic artery and mesenteric hematoma | Aneurysm and stenosis of the celiac, SMA, hepatic artery | N/A | Embolization with N-butyl cyanoacrylate for aneurysm in the SMA | N/A | N/A | Improved |
| 8 | 54 | 76 | F | N/A | Abdominal pain, nausea | IMA | Mesenteric hematoma | Aneurysm in IMA | N/A | Embolization with coil | N/A | N/A | Died |
| 9 | 55 | 59 | M | N/A | Abdominal pain, shock | SMA, RA, gastroepiploic, splenic | SMA dissection, aneurysm in RA, gastroepiploic, splenic artery; rupture of the splenic aneurysm | Saccular aneurysms and multiple stenotic region in gastroepiploic artery | Medial island spared from mediolysis | Emergency embolization of the splenic artery, resection of aneurysm in the gastroepiploic | N/A | N/A | Improved |
| 10 | 56 | 57 | M | N/A | Abdominal pain, diarrhea | SMA | Ascites throughout the abdomen | Aneurysm in SMA | N/A | Transcatheter arterial embolization | N/A | N/A | Improved |
| 11 | 57 | 60 | M | N/A | N/A | SMA | Rupture of the aneurysm of the MCA | Multiple beaded patters and aneurysm in SMA | N/A | Surgical resection | N/A | N/A | Improved |
| 12 | 47 | 25 | F | N/A | Anorexia, abdominal pain, diarrhea | SMA, hepatic | Ischemic colitis of the splenic flexure | Occlusion of IMA; stenoses of the hepatic artery | Patchy, isolated destruction of the arterial media involving both the internal and external elastic laminae | Partial colectomy of the splenic flevure | N/A | N/A | Improved |
| 13 | 58 | 53 | M | N/A | None | Celiac, SMA, splenic | Aneurysm in splenic, celiac, SMA; dissection in the celiac. | Aneurysm in the celiac, splenic, and SMA | N/A | Embolization with coil and aortic stent graft | N/A | N/A | Improved |
| 14 | 59 | 51 | M | N/A | Abdominal pain, shock | SMA, IMA | Abdominal hemorrhage | Active bleeding from SMA | N/A | Embolization and ligation of the branchs of the SMA | N/A | warfalin | Improved |
| 15 | 60 | 29 | F | N/A | Hypertension | SMA, RA, hepatic | Renal cortical nephrograms | Scattered microaneurysms in SMA, RA, hepatic artery | Segmental lesions of the media with loss of smoth muscle cells | Anti-coagulants | N/A | warfalin | Improved |
| 16 | 61 | 55 | F | N/A | Abdominal pain | Celiac, SMA, hepatic, splenic | Unremarkable in vessels | Aneurysms in celiac, SMA, hepatic, splenic artery | N/A | Anti-coagulants | N/A | warfalin followed by aspirin | Improved |
| 17 | 62 | 56 | M | N/A | Abdominal pain, shock | SMA | Aneurysm in MCA, SMA dissection | Saccular aneurysms in the MCA; dissections in the SMA | N/A | Embolization with coil | N/A | N/A | Improved |
| 18 | 63 | 64 | F | N/A | Abdominal pain, back pain, nausea | SMA, IMA, hepatic | Hematoma in the anterior pararenal space inferior to pancreatic tail; bleeding from aneurysm | Multiple aneurysms in the SMA, IMA, hepatic artery | N/A | Conservative | N/A | N/A | Improved |
| 19 | 64 | 60 | F | Hypoxia | Hypoxia, hypotension, cardiopilmonary arrest | SMA | Large hematoma in the retroperitoneal and intraperitoneal space; SMA aneurysm | Aneurysms and beaded appearance in the SMA | N/A | Conservative | N/A | N/A | Improved |
| 20 | 65 | 36 | M | N/A | Abdominal pain | Celiac, hepatic, anterior inferior pancreaticoduodenal artery | Stenosis and aneurysms in anterior inferior pancreatic duodenal artery | Aneurysms and beaded like appearance in the anterior inferior pancreaticoduodenal artery | N/A | Embolization with coil | N/A | N/A | Improved |
| 21 | 66 | 47 | M | N/A | Loss of consciousness, headache, abdominal pain | SMA | SAH, massive intraperitoneal hematoma | Beaded like appearance in SMA; dissection in VA | Medial islands and medial degenerations in SMA | Embolization with coil for VA and SMA. Surgical resection of part of middle colic artery and descending colon. | N/A | N/A | Improved |
| 22 | 67 | 79 | M | N/A | Abdominal pain, hypotension | IMA | Active bleeding from IMA and hemorrhage | N/A | Reduplication of the internal elastic lamina with arterial dissection within the tunica media and thrombus at the site of rupture | Surgical resection of left colic artery | N/A | N/A | Improved |
| 23 | 68 | 40 | M | N/A | Abdominal pain | Celiac, SMA | Extensive dissection of SMA with the thrombotic occlusion. stenosis and dilation of celiac artery | N/A | N/A | Conservative | N/A | N/A | Improved |
| 24 | 69 | 32 | M | N/A | Abdominal pain | IMA, RA | Aneurysm in renal and IMA, massive amount of hemorrhage | Stenosis and aneurysm in the RA | Media shows myxoid degeneration in the outer one-third adjacent to the adventitia | Surgical hemostasis and left hemicolectomy | Yes, N/A | N/A | Improved |
| 25 | 70 | 58 | M | N/A | Abdominal pain | SMA | Mesenteric hematoma and right inguinal hernia with unremarkable small bowel | Beaded like appearance in SMA | N/A | Immunosuppressive therapy | N/A | N/A | Improved |
| 26 | 71 | 57 | M | N/A | Hypertension, abdominal pain | SMA | Arterial dissection with luminal stenosis and aneurysm formation at the distal portion of the SMA | Segmental dilatation, aneurysm in the SMA | Vacuolization and decrease in the number of vascular smooth muscles | Aneurysmectomy and bowel resection | Ca-blocker | N/A | Improved |

M: Male; F: Female; N/A: Data not applicable; SMA: Superior mesenteric artery; IMA: Inferior mesenteric artery; RA: Renal artery; CT: Computed tomography; MCA: Middle cerebral artery.