# Image Case: Aortic Dissection: Uncommon Cause of Agonizing Abdominal Pain

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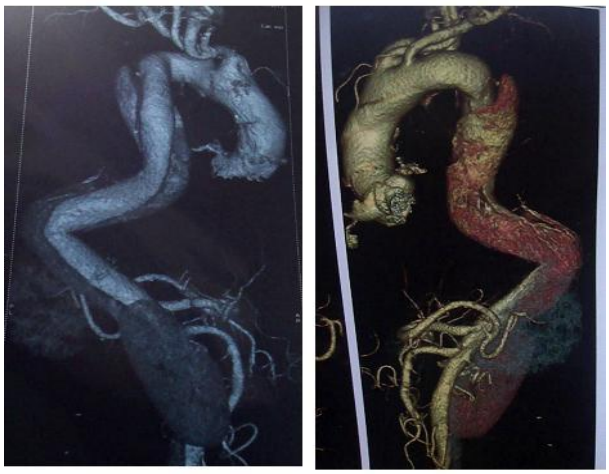
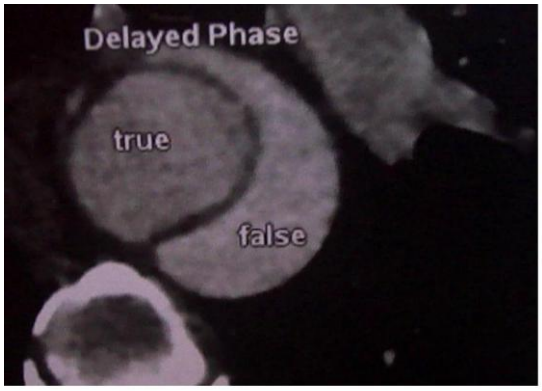
We reported a 59 years old male presented with severe agonizing abdominal pain just to the left side of the umbilicus and referred to the left shoulder. The patient was hypertensive on bisoprolol but no history of acute coronary syndrome. He was misdiagnosed at a primary health care 5 days before diagnosis. When presented he was hemodynamically stable with blood pressure 130/80. On abdominal examination mildly tender oblong mass was felt to the side of the umbilicus. The ECG examination was irrelevant. On gray scale abdominal ultrasonographgy a double channel abdominal aorta was seen that was later confirmed by Doppler study. CT angiography showed large intimal dissection sparing the aortic arch distal to the left subclavian artery and extends all through the descending thoracic and abdominal aorta till the bifurcation with small extension to the left common iliac artery (Figure 1). The true lumen (Figure 2) was seen along the right of the false lumen (well opacified along the left side of the true lumen). Fortunately, the celiac, superior mesenteric and right renal arteries were seen originating from the true lumen. The left renal artery was involved by the false lumen and it was patent (Type 3 DeBakey- Type B Stanford aortic dissection). The patient was operated upon with endoprothesis replacement. The reported rate of primary abdominal aortic dissection is less than 2%, compared with that of ascending aortic dissection (70%), descending aortic dissection (20%), and aortic arch dissection (7%) [1]. Abdominal aortic dissection presented with acute and severe abdominal pain is not common [2] and this entity of caused should not be overlooked particularly in elderly and hypertensive patients.

## REFERENCES

1. Roberts CS, Roberts WC. Aortic dissection with the entrance tear in abdominal aorta. *Am Heart J* 1991;121:1834–5.
2. Borioni R, Garofalo M, De Paulis R, Nardi P, Scaffa R, Chiariello L. Abdominal Aortic Dissections: Anatomic and Clinical Features and Therapeutic Options**.***Tex Heart Inst J*. 2005; 32(1): 70–73.



Fig(1): Showed large intimal dissection sparing the aortic arch distal to the left subclavian artery and extends all through the descending thoracic and abdominal aorta.




Fig(2): The true lumen was seen along the right of the false lumen (well opacified along the left side of the true lumen).