Median arcuate ligament syndrome remains a diagnosis of exclusion. Though the most common symptom tends to be postprandial fullness, many of its symptoms are nonspecific and overlap with other syndromes. Differential diagnoses include cholecystitis, pancreatitis, gastric outlet obstruction, GERD, and chronic intestinal ischemia. Gastric outlet dysfunction will almost always present with vomiting and mechanical obstruction will be evident on imaging. GERD occurred concomitantly in our patient, and was confirmed by EGD after a failed 8-week course of proton pump inhibitor. As mentioned in the case, amylase, lipase, liver function tests, and a RUQ ultrasound were within normal limits, placing cholecystitis and pancreatitis lower on our differential. Our patient lacked a history of vascular disease of other organs (myocardial infarction, cerebrovascular disease, peripheral vascular disease) and fear of eating (sitophobia), which are signs to be wary of in chronic mesenteric ischemia. Also, our patient did not have abdominal pain out of proportion to exam or an abdominal bruit, which are typical physical exams findings in chronic mesenteric ischemia. If concerned, a CTA of the abdomen should be offered for evaluation in such patients and would be appropriate to perform if considering a diagnosis of either chronic mesenteric ischemia or median arcuate ligament syndrome.

Our patient was offered surgical decompression, but he refused any intervention. On follow up, he continued to remain symptomatic.

References: