

A RARE CASE OF GANGRENEOUS ILEUM UNCOMMON ENTITY OF SMALL BOWEL OBSTRUCTION***¹Dr.Dhilipan pradap, ²Prof.Dr.Anvar Ali and ³Dr.Ravishankar**

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ABSTRACT

Small bowel obstruction (SBO) is one of the most common acute surgical conditions that require urgent evaluation and treatment. Several common causes are known in the general surgical practice, and the causes are different in the developing and developed world. In this article, we present a case of an acute SBO,Gangreneous ileum secondary to a Ileal constrictive Band in a 44 years old Indian female patient.

Keywords: Gangreneous ileum Small bowl obstruction

1.INTRODUCTION

Intestinal ischemia is an uncommon condition presenting particular problems of diagnosis and management. The prevalence of the disease is difficult to establish. In India, approximately 2000 deaths a year are attributable to intestinal vascular insufficiency, with 1883 deaths in 2000. Of these, at least 833 (44%) were classified as acute(834 being unspecified as either acute or chronic).

It affects women more than men by a ratio of 2:1. The incidence is rare below forty-five years of age and the majority of deaths occur after the seventh decade. Most cases are caused by emboli (40%-50%), followed by arterial thrombosis (25%-30%), venous thrombosis (10%), and non-occlusive mesenteric ischemia (20%).

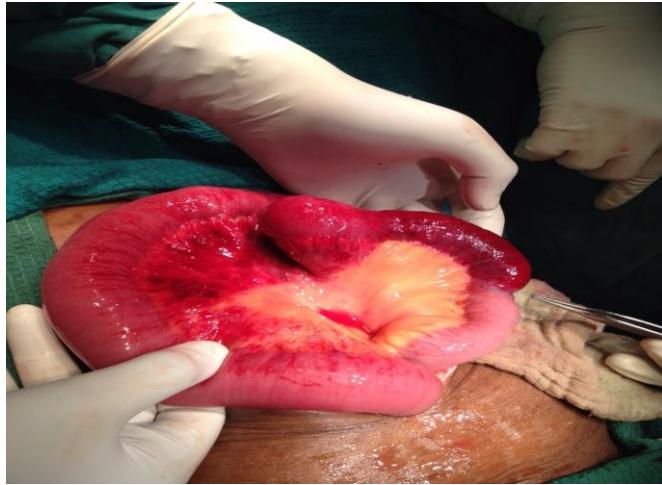
Mortality is high and has changed little since the 1970s, despite interventional advances. A 44 years old female patient presented on 3rd march,2015,to the casualty of Rajah muthiah medical college & Hospital,Chidambaram, with a complaint of crampy abdominal pain of 3 days duration. She had also vomiting of ingested and bilious matter and progressive abdominal distention. She developed absolute constipation 1 day before the presentation. The patient had no history of previous surgery and symptoms suggestive of

hernia. Upon examination, she was in pain. Her pulse rate was 90/min and feeble, blood pressurewas 100/70mmHg, respiratory rate 32/min, temperature 36.5°C and saturation of oxygen 97% with atmospheric air. Her tongue and buccalmucosa were dry. Abdomenwas grossly distended with generalized tenderness and guarding. The bowel sounds were hypoactive. Digital rectal examination revealed empty rectum, no blood on examining finger. With the impression of gangrenous Small Bowel Obstruction. She was resuscitated and investigated; hematocrit was normal and WBC 10.6× 10³. Plain abdominal film showed dilated loops of small bowel with insignificant air–fluid levels and absent rectal gas shadow. Ultrasound Abdomen showed Features of Ascites with dilated bowel loops. Patient was prepared and urgent exploratory laparotomy done through midline incision. Upon entering the peritoneal cavity, there was ~1000 ml dark hemorrhagic fluid and Grangreneous proximal ileum of about 20cm with a constrictive illeal band in the distal part. Resection and Anastomosis was done. After giving adequate peritoneal lavage,wound was closed with dependent drains.

Postoperatively the patientwas kept NPO, IV fluids, IV antibiotics and analgesics. Clear fluid diet started on the 4th postoperative day, and solid diet the next day. On the 6th postoperative day, patient developed watery diarrhea but had no fever, abdominal pain or vomiting. The abdomen was soft, no tenderness, no sign of fluid collection and normoactive bowel sound. All investigation including the white cell count and abdominal ultrasound were normal.

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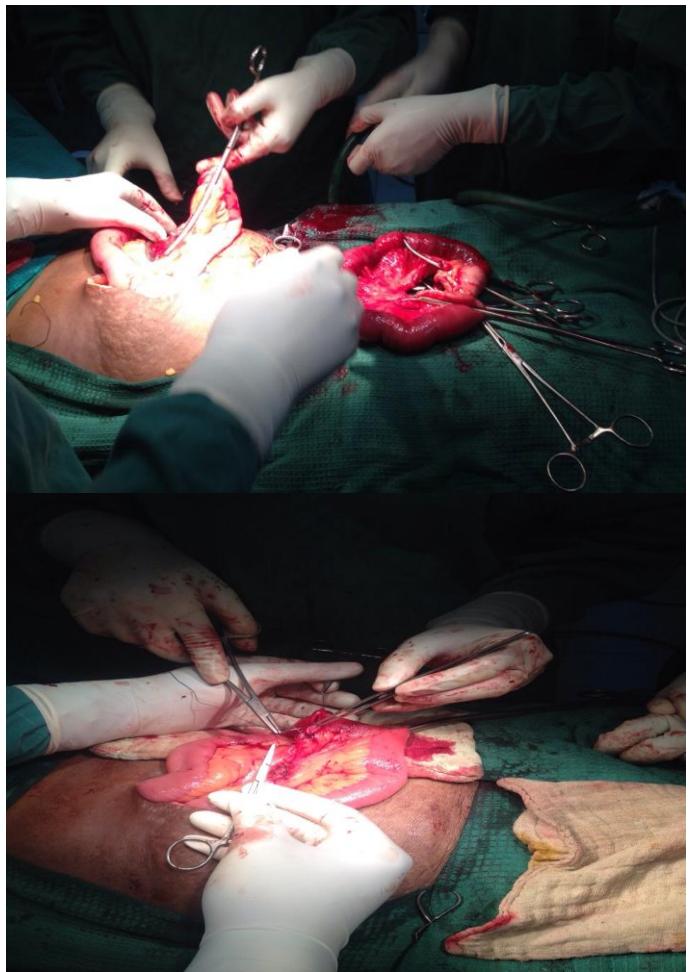
With the assessment of short bowel syndrome, the patient was continued with fluid replacement, oral rehydration solution. Patient was advised on diet modification. The diarrhea decreased without the need for anti-diarrheal drugs. She was discharged on her 10th postoperative day, and diarrhea completely stopped. Patient followed for the next 5 months and had uneventful course except difficulty to gain her previous weight. Histopathology reports reveals intestinal wall with extensive areas of haemorrhagic necrosis, consistent with the diagnosis of Gangrenous intestine.



Picture 1:Segmental gangrene of ileum with a constrictive band



Picture 2 & 3: Resection of the gangrenous segment of ileum



Picture 4 & 5:Resection and Anastomosis done



Picture 6:Uneventful operative period

2.DISCUSSIONS:

Treatment should be started as early as possible with aggressive IV fluid resuscitation, insertion of nasogastric

tube and broad spectrum IV antibiotic. When the patient is adequately resuscitated, Emergency laparotomy should be performed through long midline incision, and the cavity should be carefully explored. In cases of intestinal knotting/Banding, the operative procedure of choice is to carefully unravel the knot/release the constriction Band if both loops are found viable, to perform an en bloc resection of the gangrenous segments if found gangrenous.

Decompression of the gangrenous segments or untying a gangrenous knot is not recommended. It is very difficult, and there is a very high risk of peritoneal contamination following rupture of the gangrenous segment. Postoperatively patient should be monitored for hydration status, anemia and signs of anastomotic leak. Depending on the length of the remaining small bowel, follow-up should include for signs of short bowel syndrome. When that happens, diet modification should be the first consideration.

In our case, the symptom of short bowel syndrome improved fast most likely because the ileo-cecal valve was intact. So, maintaining the ileocecal valve should be considered when possible.

Though Gangreneous ileum due to a constrictive band is a rare clinical entity, it should be always considered in the differential diagnosis of patients with signs and symptoms of SBOs. Because the condition is associated with high rate of morbidity and mortality, a high index of suspicion remains the most useful tool. The possibility of short bowel syndrome as the complication of the treatment should be considered and treated accordingly. Whenever possible, avoid by passing or resection of the ileo-cecal valve.

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