Original Research Paper

Volume-8 | Issue-9 | September-2018 | PRINT ISSN No 2249-555X

Surgery

SPONTANEOUS ISOLATED CAECAL PERFORATION – A RARE CASE PRESENTATION.

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KEYWORDS :

INTRODUCTION-

Spontaneous perforation of colon (SPC) is a rare entity, defined as perforation of apparently healthy colon in absence of diseases or injury [1,2]. It is more common at the extremes of age especially elderly & premature infants but no age is exempted[3,4], It results in peritonitis and free air under right dome of diaphragm necessitates laparotomy. In spontaneous perforation of colon are more common in sigmoid colon, caecum involves rarely.[5,6,7]

CASE REPORT-

A 15-year-old female presented with complaint of fever since 1 month, acute abdominal pain, distention of abdomen and inability to pass flatus and faeces from 5 days. Pain started in periumblical region, sudden onset, severe become generalized within few hours, associated with vomiting. Patient also complaints of low-grade fever from last 1 month not associated with chills and rigor, no diurnal variation. There was no history of altered bowel habit, bleeding per rectum, loss of weight and appetite, cough, trauma or any surgery or intervention. Patient complained of similar kind of febrile episode when she was 8 year old. At that time fever was mild and associated with auto amputation of 2nd, 3rd and 4th distal phalanx of right hand. For this condition she was consulted to a physician but no records are available. There was no history of tuberculosis , typhoid or amoebiasis in past.

On general examination: patient was conscious and alert, pallor present, BP= 94/60 mm Hg, PR= 138 /min with amputated 2nd, 3rd and 4th distal phalanx of right hand. In local examination abdomen is distended generalized tenderness, guarding and rigidity present with absent bowel sound and liver dullness masked, per- rectal examination showed remnant of stool, no mass lesion. Blood investigation: CBC- Hb- 6.2 gm/dl, Total leucocyte count 16500 with differential increase in neutrophils 87% and serum albumin/protein- 2.4/5.3 gm/dl. Other parameters were within normal limits. On X ray abdomen AP erect and chest X-ray PA view showed gas under right dome of diaphragm (fig.1). Patient was resuscitated in emergency. Preoperative diagnosis of hollow viscus perforation with peritonitis was made and patient was taken up for emergency laparotomy.

On laparotomy there was a caecal perforation with fecal peritonitis (fig 2). The perforation was approximately 0.2x0.3 cm with adjacent inflammation. Rest of bowel loops, liver and spleen were normal. Due to severe anemia and low value of albumin, ileostomy with mucous fistula of colon was made after thorough peritoneal lavage. Postoperative period was uneventful and patient was discharged on 8th post op day. Histopathology reports show nonspecific caecal perforation. On rheumatological consultation diagnosis of polymyositis was made and they started treatment in their follow up.

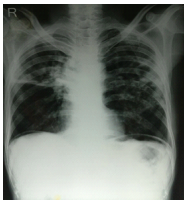

Fig 1 Chest X- Ray PA view showing gas under Right dome of diaphragm

Fig 2. Single perforation at caecum

DISCUSSION-

A caecal perforation is a rare entity. It is usually associated with closed loop obstruction[8], ogilville syndrome[9,10], trauma[11], inflammatory bowel disease[12], infection such as tuberculosis[13] and typhoid [12] , diverticular disease [14] , and rarely associated with foreign bodies [15] or sometime spontaneous perforation [16]. The exact cause of spontaneous perforation is unknown, however some condition like hypothyroidism, intestinal hypomotility, chronic constipation and fecal impaction are associated with it [17]. Most cases of spontaneous colonic perforation associated with connective tissue disorder such as Marfan, Ehlers-Danlos Syndrome or polyarteritis nodosa which affect collagen synthesis and also affects blood vessels.[18] In the current patient cause may be polymyositis, a connective tissue disorder as the diagnosis made postoperatively. This is one of the example of spontaneous idiopathic caecal perforation.

CONCLUSION-

Spontaneous caecal perforation is rare entity, in any patient suggestive of hollow viscous perforation with history suggestive of any rhematological disorder. We should keep spontaneous perforation of colon as our preoperative differential diagnosis and if diagnosis is not confirm preoperatively, consultation with a rheumatologist is essential.

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