



A RARE CASE REPORT OF JEJUNAL VOLVULUS FOLLOWING OPEN APPENDECTOMY.

General Surgery

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ABSTRACT

Post operative complication of open appendectomy are wound infection, intra-abdominal abscess, paralytic ileus, faecal fistula, bleeding, wound dehiscence, intestinal obstruction due to adhesions, venous thrombosis and embolism.^{1,2} Adhesive intestinal obstruction is one of the rare complications of appendectomy.³ Here, we report a rare case of development of jejunal volvulus due to adhesion bands following open appendectomy.

KEYWORDS

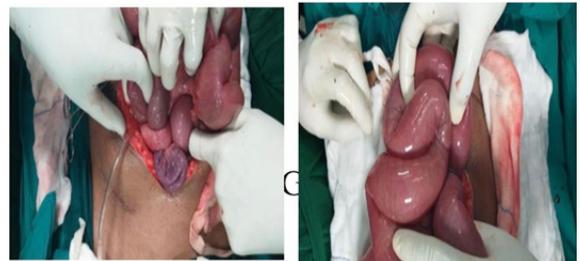
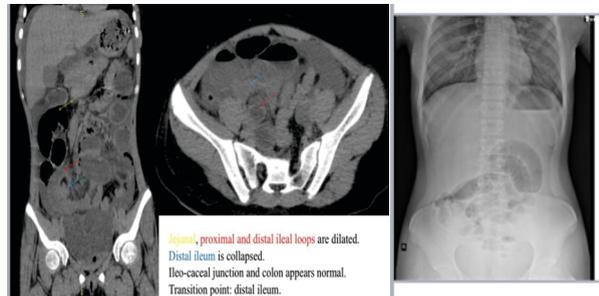
Jejunal Volvulus, Intestinal Obstruction, Adhesion Band, Appendectomy

Introduction –

Appendectomy is one of the most commonly performed operative procedures.⁴ Post-operative complications following appendectomy are relatively uncommon and reflect the degree of peritonitis that was present at the time of operation. The grade of appendicitis and the risk of post operative complications further depends on various factors – inflamed appendix without gangrene/necrosis, gangrenous appendix with necrosis, perforated appendix with free pus in abdominal cavity. In adults, common predisposing factors for post operative complications are adhesions, peri-diverticulitis, long pelvic mesocolon, narrow attachment of sigmoid mesocolon. Small bowel obstruction (SBO) is uncommon in adult surgical procedures, occurring mainly due to postoperative adhesions.

Case Report –

16 year old female, came with complaints of generalized continuously progressing, dull aching pain in the abdomen, mainly in the epigastric and umbilical region, aggravating on taking food and relieves on vomiting since 1 day. Pain was associated with multiple episodes of vomiting, non-bilious, non-projectile, containing food particles and water. The patient underwent open appendectomy two weeks ago in outside hospital. Postoperatively, patient started having intermittent pain in upper abdomen associated with non-bilious vomiting, and was given conservative management for the same. On examination, patient was afebrile, Pulse 90/min, Blood Pressure 100/60 mm of Hg, Respiratory Rate 20/min. Abdomen was distended, tenderness present in epigastric and umbilical region, hyperperistaltic sounds present in the upper abdomen, healthy scar of open appendectomy present in Right Iliac Fossa. Immediate resuscitative measures given for intestinal obstruction. Complete Blood picture was within normal limits. X ray erect abdomen was suggestive of multiple air fluid levels in central abdomen, suggestive of small bowel obstruction. There was no evidence of air under diaphragm. A trial of conservative management was given for one day. However, there was no relief in symptoms, abdominal distension increased, and further investigations were planned. MSCT (Abdomen + Pelvis) (Plain + iv contrast) suggestive of large ascitic collection with jejunal distension with liquid and air and contracted ileum. Findings were suggestive of small bowel obstruction due to adhesions. Patient was taken up for exploratory laparotomy. Findings were multiple adhesion bands, jejunal obstruction due to a jejunal volvulus around an adhesion band. No bowel ischemia noted. Adhesiolysis was done, the band causing obstruction released. Postoperatively, patient was shifted back to the ward and antibiotics and analgesics given. On POD 3, patient was started on liquids orally and gradually started with soft diet and on POD 6, she was discharged



Discussion :

The rates of post operative adhesion is not well-known but the reported risk ranges from 0.2-10.7%.⁵

Mechanical intestinal obstruction remains one of the most common surgical emergencies. There has been considerable alteration in the nature of the causes of intestinal obstruction. There are some controversies regarding gender as a risk factor for developing post-operative adhesions. In a study by DR NASIM AKTAR, it was seen that the incidence was higher among males; on the other hand Riber et al, found a higher incidence among females. The interval between a patient's last surgery and presentation of adhesive intestinal obstruction is widely distributed. In our patient, the interval between appendectomy and development of intestinal obstruction was 2 weeks. The higher incidence of intestinal obstruction in patients with normal appendix may be due to the fact that finding of normal appendix triggers the search for other pathology, leading to more trauma to the serosa of the small intestine, hence increasing the chances of postoperative adhesive obstruction. On the other hand, the degree of inflammation in case of a perforated appendix correlates to the magnitude of the healing response, leading to formation of more fibrous adhesions, which could precipitate intestinal obstruction. In support to this notion is our findings that infection and mechanical trauma constitute the most essential causes of adhesions.

Perforated appendix, male gender, advancing age, and negative appendectomy are suggested as the main risk factors. Sparing the peritoneum from severe infection by early appendectomy and reduction of mechanical trauma during surgery are achievable means for the reduction of postoperative adhesions.

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