Original Research Paper Surgery

A Rare Case of Jejunal Diverticulosis

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KEYWORDS

introduction
Diverticulosis[1] refers to condition in which inner lining of layer of intestine bulges out through the outer muscular layer. Inflammation and infection of one or more such diverticulum is diverticulitis. More commonly these diverticuli are seen in western world with low intake of dietary fibres and are asymptomatic in majority of the cases but can lead to fatal complications.

Case report
A 62 year male came with complaints of pain in the abdomen for 2 months, dull aching , non-radiating in the nature with intermittent attacks of colic associated with loss of appetite.

On examination : he was haemodynamicaly stable with vague tenderness all over the abdomen, bowel sounds were present. Per rectal examination was normal. Ultrasonography and x-ray abdomen were suggestive of gaseous distension of abdomen. Patient was treated conservatively as a case of sub acute intestinal obstruction and relived. CT scan of the abdomen was done at interval of 3 weeks and it was found to be normal. After one and half month same patient presented in emergency with severe pain in the abdomen and distension for two days. On examination patient had tachycardia hypotension and guarding rigidity all over abdomen. Liver dullness was obliterated. Abdominal tap negative. X-ray abdomen showed gas under the diaphragm. USG abdomen was suggestive of pneumoperitoneum with perforation and ascities.

Jejunaldiverticuli

After initial resuscitation with intravenous fluids and antibiotics, emergency laprotomy was done the findings of which were multiple jejuna diverticula approximately 10 cm from DJ flexure extending over to jejunum for almost 60 cm along mesenteric border. Large phelgmon was seen in relation with perforated diverticuli with mesenteric lymphadenopathy. Biopsy of lymph node was done. The involved segment was resected with end to end ileojejunal anastomosis. Post operative patient was uneventful and discharged on 8th day postoperatively. Now doing well.

Histopathology report showed multiple jejunal diverticulosis with diverticulitis with mesenteric lymph node positive for reactive lymphadenitis.

Discussion
Diverticuli most commonly affect sigmoid colon as a whole and duodenum most commonly involved in small intestine diverticulosis. Anatomically they are seen on mesenteric border but may be seen on anti –mesenteric border apart from meckel's diverticulum [8,9,10].

There are two types of diverticuli [2,3,] true (congenital) with all layers of intestine bulging out of the bowel wall eg. Meckel's diverticulum and false(acquired/pseudo) diverticuli in which mucosa and submucosa bulges out through muscularis mucosa eg. duodenal , jejunoileal diverticuli. Males are more commonly involved in the age group of 26 to 87 years with mean of 67 yrs with prevalence rate of 1% in jejunoileal diverticuli. Isolated jejunal are 80%, ileal 15%, and jejunoileal 5% [5.]

Diverticulum forms when pressure inside bowel builds usually because of constipation. Most of the diverticuli are at point of entry of blood vessels as pulsion , muscle coat defect and congenital .most of the patients are asymptomatic with symptoms seen only in 10 to 30 % as vague abdominal pain, anorexia, diarrhoea, flatulence, steatorrhoea, megaloblastic anaemia, which are nothing but signs of blind loop syndrome. Most diverticuli are diagnosed incidentally on imaging, endoscopy and surgery. USG and CT scan abdomen are usually inconclusive but can be best diagnosed on barium meal follow through and enteroclysis. 6 to10% of patients show complications [4, 5, 6] which includes diverticulitis, perforation, haemorrhage, intestinal obstruction, infestation with roundworms or threadworms. Perforation can be due to foreign body or enterolith leading to generalised peritonitis, localised abscess, or fistula [7.] Haemorrhage is rare cause of malena but can be massive and repeated. Obstruction can be due to post inflammatory adhesions or volvulus. Blind loop syndrome manifests as diarrhoea, abdominal pain, anaemia, steatorrhoea and vit B12 deficiency.

Treatment[3] includes high fiber diet and in patients with blind loop syndrome antibiotics, vit B12 supplementation, and regular follow up. If medical management fails or complicates, surgery required as simple divrticulectomy, resection with end to end anastomosis. No inversion of diverticulum should be done as there is every chance of intussusceptions. Jejunoileal diverticuli are paper thin and may lie concealed in the fat of mesentery despite barium meal study.

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