ORIGINAL RESEARCH PAPER

General Surgery

RECURRENT SIGMOID VOLVULUS: A CASE REPORT

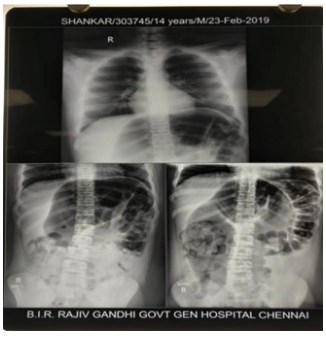
KEY WORDS: Sigmoid Volvulus, Obstruction, Colonoscopy

Paulia Devi	Institute Of General Surgery, Madras Medical College And Rajiv Gandhi Government Hospital, Chennai, Tamilnadu, India
Arun Prakash Ilangovan*	Institute Of General Surgery, Madras Medical College And Rajiv Gandhi Government Hospital, Chennai, Tamilnadu, India *Corresponding Author
Maniselvi Swamidurai	Institute Of General Surgery, Madras Medical College And Rajiv Gandhi Government Hospital, Chennai, Tamilnadu, India
Kannan Ross	Institute Of General Surgery, Madras Medical College And Rajiv Gandhi Government Hospital, Chennai, Tamilnadu, India

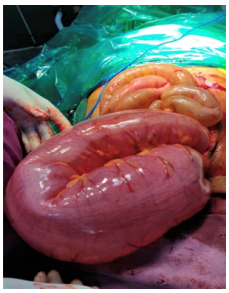
CASE REPORT:

A 16 year old boy came with C/O abdominal pain for 2 days. H/o abdominal distension for 2 days. H/o vomiting for 2 days. H/o obstipation for 2 days. No h/o fever and loose stools. No H/o trauma. No H/o hiccups and breathlessness. No H/o jaundice, haemetemesis and malena. Patient was previously treated with laparotomy and sigmoidopexy for sigmoid volvulus 6 months back. No h/o any comorbids and psychotropic drugs abuse. On examination abdomen is distended. Umbilicus in midline. All quadrants moves with respiration. Midline laparotomy scar- present. No sinuses and distended dilated veins. No mass visible and no VGP and VIP. On palpation not warm, diffuse tenderness is present. Abdomen is soft, guarding is present. No rigidity. No other mass palpable. No hepato splenomegaly. No fluid thrill. On percussion – tympanitic in resonance. No obliteration of liver dullness. On auscultation no bowel sounds heard. On per rectal examination – no fecal staining and no other masses palpable. On investigation X ray showed classical- coffee bean appearance. CT abdomen showed sigmoid volvulus. Patient was proceeded with emergency laparotomy with sigmoidectomy and end to end anastomosis was done. Post op period was uneventful. Patient started on orals on POD-6 and discharged on POD-12.

X-RAY PICTURE



INTRA OP PICTURE



DISCUSSION:

Sigmoid volvulus common cause of large bowel obstruction. Most common in india and accounts for about 7% of intestinal obstruction. Old age men are commonly affected. Most common in patients with chronic constipation with laxative abuse. Predisposing factors include- adhesion, peri diverticulitis, long pelvic mesocolon and narrow sigmoid mesocolon attachment. Rotation is anti clockwise and it requires one and half turn to cause obstruction and gangrene. Sometimes ileum comes around the base causing compound sigmoid volvulus termed as ileo sigmoid knotting. Differential diagnosis includes oglivies syndrome, faecal impaction, and carcinoma recto sigmoid junction. Management includes adequate resuscitation and ryles tube aspiration. Patient was proceeded with laparotomy if bowel is not viable proceeded with resection and colostomy- hartmanns procedure . paul Mikulicz operation is also considered. This is followed by reversal after 6 to 12 weeks. If the patient is elderly with comorbids colonoscopic detorsion followed by elective management later. Most of the cases are managed with resection and ostomy. As left sided primary anastomosis is associated with high leak rate. Sigmoidopexy is no longer recommended as it is associated with high recurrence rate of about 55%. As seen in our case. Here we proceeded with sigmoidectomy and ene to end anastomosis as patient is young with no peritoneal contamination and considering the need for third procedure if planned for hartmanns.

REFERENCES

1. Bailey and love text book of surgery
2. Sabiston text book of surgery
3. Kuzu MA, Aslar AK, Soran A ,Polat A, Topcu O, Hengirmen S. Emergent resecton for acute sigmoid volvulus:results of 106 consecutive cases.Dis colon rectum 2002;45:1085-90. [Google scholar]
4. Chung Yf, Eu Kw, Nyam Dc, Leong AF, HO, YH, Seow-Cheon F. Minimizing Recurrence After Sigmoid Volvulus. Br J Surg. 1999;86:231-3