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CASE STUDY OF INTESTINAL OBSTRUCTION(ILEOCOLIC INTUSSUSCEPTION) AND RESECTION- ANASTOMOSIS

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INTRODUCTION

Intussusception: Intussusception is commonly defined as telescoping of a proximal part of an intestinal loop towards the distal part of the loop. The incidence of intussusception is 1–3 cases per 1,000,000 population per year. The condition is more frequent in children than in adults. Patients present sometimes with nonspecific symptoms. The majority of patients come to hospital with abdominal pain and vomiting. As these are unspecific symptoms, diagnosis of intussusception could be missed or even delayed before one would entertain intussusception as a cause of abdominal pain. The unspecific presentation makes it difficult to define clearly the diagnosis before surgical operations. Ordinarily, half of these cases are diagnosed in theater. Helpful diagnostic tests include plain abdominal film, abdominal CT scan and ultrasound. Operative procedures to reduce the intestine is the treatment modality of intussusception. In this paper we present a patient with intussusception with nonspecific symptoms who presented to Seth Tarachand Hospital, Rasta Peth, Pune and emphasize the importance of early CT scan for quick and definitive diagnosis.

Resection-Anastomosis

Small bowel resection is a commonly performed procedure in general surgery. The length of the small bowel allows for simple resection without significant compromise to the gastrointestinal (GI) system function in most situations. Familiarity with the bowel, as well as the steps needed to perform a safe resection, are key components of surgical training, even for those who do not specialize in GI surgery. This article will outline the basic steps in a small bowel resection, characterize certain situations requiring resection, and discuss the possible

outcomesand complications associated with the procedure.

The creation of a join between two bowel ends is an operative procedure that is of central importance in the practice of a general surgeon and is still by far the most common surgical procedure, especially in the emergency setting, and is also commonly performed in the elective setting when resections are carried out for benign or malignant lesions of the gastrointestinal tract, done by the present day General Surgeon. This procedure restores intestinal continuity after removal of a pathological condition affecting the bowel. A disastrous complication of intestinal anastomosis is anastomotic leak resulting in peritonitis, which is associated with high morbidity and mortality. Proper surgical technique and adherence to fundamental principles is imperative to ensure successful outcome after intestinal anastomosis.

Ayurvedic Point of View

हेतु -

यस्यान्त्रमन्नैरुपलेपिभिर्वा बालाश्मभिर्वा सहितैः पृथग् वा ।
सञ्चीयते तत्र भलः सदोषः क्रमेण नाड्यामिव सङ्करो हि ।।
निरुध्यते चास्य गुदे पुरीषं निरेति कृच्छ्रादपि चाल्पमल्पम् ।
हृन्नाभिमध्ये परिवृद्धिमेति तच्चोदरं विट्समगन्धिकं च ।।

सु.नि. ७/१७,१८

गुम्फितं व्याकुलितं परस्परमतिक्रान्तमित्यर्थ । डल्हण

लक्षणे-

तृष्णादाह ज्वर मुख तालु शोषोरुसादकासश्वासदौर्बल्यारोचकाविपाक वर्चोमूत्रसङ्गाध्मानच्छर्दि क्षवथु शिरोहन्नाभिगुद शूलानि अपि चोदरं मूढवातं स्थिरमरुणं नीलराजि सिरावनद्धमराजिकं वा प्रायो नाभ्युपरि गोपुच्छवद्धिनिवर्तते इति एतद् बद्धगुदोदरमिति विद्यात् ।। च. चि. १३/४१

बद्धोदर शल्यकर्म चिकित्सा

बद्धगुदे परिस्राविणि च स्निग्धस्विन्नस्याभ्यक्तस्याधो नाभेर्वामतश्चतुरङ्गुलमपहाय रोमराज्या उदरं पाटयित्वा चतुरङ्गुलप्रमाणान्यस्त्राणि निष्कृष्य निरीक्ष्य बद्धगुदस्यान्त्रप्रतिरोधकरमश्मानं वालं वाऽपोह्य मलजातं वा ततो मधुसर्पिर्भ्यामभ्यज्यान्त्राणि यथास्थानं स्थापयित्वा बाह्यं व्रणमुदरस्य सीव्येत् ।

सु.चि. १४/१७

बद्धोदर स्विन्नाय सतैललवणमूत्रं तीक्ष्णं निरुहमनुवासनं च दद्यात् । स्रंसनानि चान्नान्युदावर्तहराणि च तीक्ष्णं च विरेचनं यच्च किचीवातघ्नम् ||

अ.सं.चि. १७/८८

CONCEPTUAL STUDY

CASE STUDY

24YRS /M C/O abdominal pain and vomiting of 3-month duration. The pain was diffuse, intermittent and more on the periumbilical area. There is no history of abdominal distension and he was passing gas. His condition gradually worsened from time to time.

There was no history of fever, no bloody vomiting. There was no known family history of intestinal obstruction.

AIM

To study the surgical and medical management of intestinal obstruction(Intussusception) and Resection-Anastomosis.

OBJECTIVES

To observe the surgical and medical management of intestinal obstruction (Intussusception) and Resection-Anastomosis.

MATERIAL AND METHODS

Name-XYZ, Age-24yrs/m, Religion –HinduOccupation- studnt.

COMPLAINTS OF: abdominal pain and vomiting of 3-month duration.The pain was diffuse, intermittent and more on the periumbilical area.

PAST HISTORY

S/H/O –No Any Surgical History

K/C/O: No HTN | No DM | No Asthma | No Koch's | No Thyroid Disorder

M/H/O- Typhoid (4 months ago)

Epillepsy (8 months ago)Jaundice (5 yrs ago)

Anaemia (Hb-1.5 gm/dl)- 8PCV+14FFP (2020)

PHYSICAL EXAMINATION

G. C – Fair & Afebrile

P -84/min, BP- 110/60 mmHg,

CVS –S1S2 N,

CNS- Conscious & Oriented

RS- AEBE clear

P/A- Soft & non tender,

B- Not Passed

M-CLEAR

GENERAL EXAMINATION

-Toxic look -Pallor,

-Icterus– Not seen

-No regional Lymphadenopathy

LOCAL EXAMINATION

Inspection

Stretch marks noted at right iliac region.

Pustules are noted over right iliac region.

No abdominal distenstion noted.

No any previous operative scars noted.

Palpation

Mass, Tenderness, Guarding

No local temperature raised.

Percussion

Dullness

Auscultation

Bowel sounds are high pitch and increase in frequency.

Investigations

Hb-13 gm%, WBC – 10380/cmm, RBC- 5.73mil/cmm

PLT – 4.14LAKH /cmm,

BSL{R} -152 mg / dl,

HIV & HBsAg- Negative

2D ECHO

CXR PA VIEWECG

USG (A+P)

Bowel lump in the right hypochondrium measuring 8.6x4.8 cm wih bowel in bowel appearance suggestive of intussusception.

Small bowel loops are dilated and air fluid filled suggestive of intestinalobstruction.
Rest of ultrasound examination of abdomen and pelvis is within normallimits.

CT (Abdomen+Pelvis) Plain and Contrast
Large ileocolic intussusception with circumferential homogeneously enhancing ascending colon, caecum, terminal ileal loops and associated enlarged mesenteric lymph nodes in the right iliac fossa.
Mild hepatomegaly and splenomegaly.

TREATMENT & MANAGEMENT

CONSERVATIVE

NBM
INJ-PIPTAZ 4.5gm I.V T.D.S IN 100 ml NS,
INJ-METRO 500mg I.V. T.D.S,
INJ-PAN 40mg IV BD
I.V. FLUIDS
RT INSERTION NO 14
FOLEYS CATHETERISATION NO. 14

SURGICAL PROCEDURE

1. Anaesthesia- Spinal
2. Position-Supine

Procedure- Exploratory Laparotomy with Resection anastomosis.
under AAP painting and draping done.
Midline incision taken Layer wise opening done.
Skin-subcutaneous fat-campers and Scarpa - rectus sheath- peritoneumopened.
Dilated bowel loops are seen.
Intussusception identified and released 10cm approx. proximal to ileocecaljunction.
Warm mop of NS kept on bowel loops.
Head point identified- intramural lymphoid mass noted which lead to intestinal obstruction and intussusception.
While releasing intussusception serosal tear sutured with Mersilk 3.0.
Intestinal clamps either side of lymphoid mass.
Resection done of lymphoid mass and small bowel.
Anastomosis done in double layer. First layer done with Vicryl 3.0 secondlayer with Mersilk

3.0.

Anastomotic leak checked by milking.

Wash given with Warm NS.

Hemostasis achieved.

Abdomial closure done with loop ethilon 1.0.

Skin closure with Ethilon 2.0.

Patient shift to ward in good condition.

Resected sample sent for Histopath.

Drain- ADK drain no 32.

Procedure- uneventful.

Blood loss-200cc.

Instruments count-checked.

Sponge count- checked.

Operation Duration- 2 hrs.

Biopsy- yes.

Culture- No.

POST OP.

INJ-PIPTAZ 4.5gm IV TDS IN 100ml NS

INJ-METRO -500 mg IV TDS,

INJ –PAN 40mg IV BD

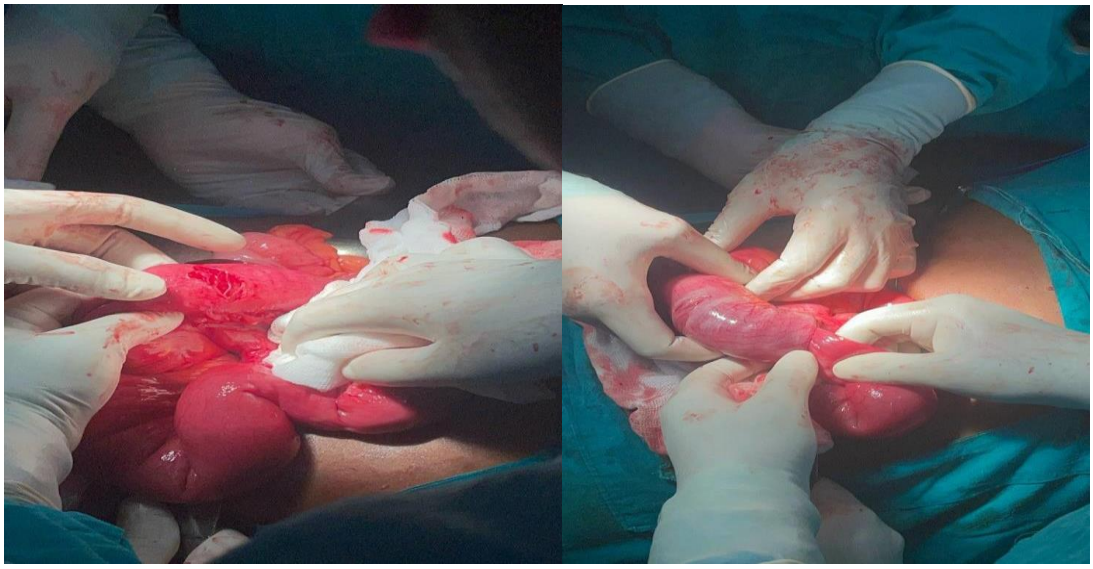
INJ T.T 0.5 CC IM STAT

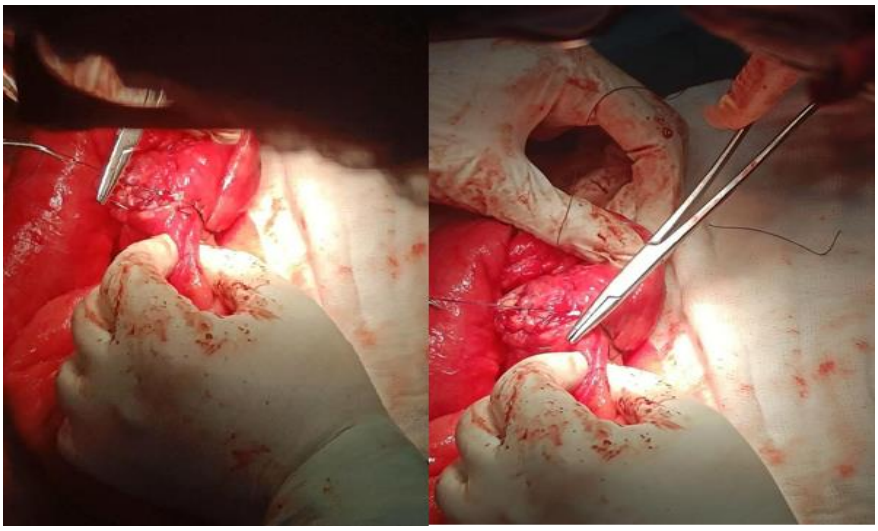
INJ PARACETAMOL 1 GM IV STAT

INJ-VIT C 2 AMPULE in 100ml NS for three day.

After 10 days ADK drain removed and dressing done healthy granulationseen -After 15 Days stitches removed and patient discharge.

RT removed after 7 daysNBM out after 7 days.





DISCUSSION AND CONCLUSION

Intestinal obstruction (Ileocolic intussusception) is rare condition & in majority cases Resection – anastomosis.

- After Resection - anastomosis patient required 15 days for completehealing of wound.
- After healing of wound, patient's counselling done and was convinced forphysiotherapy and spirometry.
- Now, patient is living his life happily.

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