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RIGHT HEMICOLECTOMY IN VIEW OF PERFORATION OF ILEOCECAL JUNCTION DUE TO LONG TERM USE OF CORTICOSTEROID TREATMENT – A CASE REPORT

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ABSTRACT

Ileocecal perforation in patients receiving corticosteroid (GCS) therapy has been reported to have mortality rates as high as 100%. High dose GCS therapy decreased the clinical expression of peritonitis to the point that recognition and therefore treatment of gastrointestinal perforation were markedly delayed.In a patient receiving high dose GCS , a high degree of clinical suspicion must accompany any new Abdominal discomfort and aggressive diagnostic efforts should be made to establish the cause. If abdominal pain persist surgical exploration should be considered. Similar case report will be discussed here.

INTRODUCTION

Hollow viscus perforation leading to peritonitis is one of the commonest emergency surgeries conducted in a surgical practice.

For a case of acute abdomen, it is the second most common cause of acute Abdomen following appendicitis. Among the cases of Hollow viscus perforations duodenal & gastric perforations are the commonest accounting to almost 60-80%. In some series followed by ileal, appendicular, large bowel.

Among verious causes of perforation, long term use of corticosteroids for any pathology canlead to gastri or intestinal ulcer, bleed or perforation.

AIM

To highlight diagnostic and therapeutic feature of ileocecal perforation due to long term use of corticosteroids & it's management in young female patient.

OBJECTIVE

To study anatomy, clinical manifestations, diagnosis and management of pathological abnormalities in GI tract due to long term use of corticosteroids to improve patient's outcome.

CASE REPORT

32 years female patient came in tarachand hospital, rasta peth with complaints of pain in abdomen all over &and more in right iliac fossa since 5 days, vomiting 5 days ago, fever 2 days ago. Giving the history of taking long term of about 10years corticosteroids for the treatment of rheumatoid arthritis. History of frequently transfusion of PCV in 2018 – four pint PCV, in 2022 – two pint PCV, in 2023 – 2 pint PCV transfusion done for anemia due to ? GIbleed , ? Malena , ? Ileal ulcers – Undiagnosed.

According to complaints and history provisionally patient was diagnosed with ? Appendicitis,? Appendicular perforation with peritonitis. So to treat the patient diagnostically and therapeutically patient posted for surgery – Exploratory Laparotomy. Patient examined – per abdomen abdomen was not Distended, tenderness at RIF.

Patient investigated for surgery thoroughly, HB – 8.2gm%, TLC – 10360/cmm, PLT – 4.79Lakh/cmm, rest RFT, Sr. Electrolyte, Sr. Amylase, Sr. Lipase, LFT, Urine routine arenormal and serology were negative. INR was raised – 1.41 so before procedure inj Vit K was injected 20mg IV twice before surgery and 2 pint PCV reserved.

USG (Abdomen+pelvis) shows normal study so purther investigation CT(abdomen+pelvis)was done – shows An I'll defined branching collection with air focus within in RIF, adjacent fat stranding with multiple enlarged reactive lymph nodes findings S/O – appendicular perforation with periappendicular collection. Mild free fluid with extensive fat stranding in RIF, long segment circumferential enhancing wall thickening in distal terminal ileum and caecum, likely reactive. So patient was posted for surgery.

Surgical management

Patient was treated with antibiotics & posted for Exploratory laparotomy with

appendicectomy sos right hemicolectomy.

Pre-operative

Patient was kept NBM since admission, Written surgery and anaesthesia consent was taken, Two pint PCV were reserved, IV antibiotics and IV fluids administered.

Operative procedure

Under spinal anaesthesia foley's catheterization done under aseptic precautions Painting and draping done.

Vertical midline incision taken of about 10 cm from supraumbilical to suprapubic region. Layerwise dissection done and peritoneum opened.

Appendix visualised in Right iliac fossa without any inflammation or perforation appears normal.

2cm away from base of the appendix at ileocecal junction sealed perforation noted with gangrenous intestinal wall of ileocecal junction.

Condition informed to relatives & discussion done with them. Dicision taken to do Right hemicolectomy.

Margins decided – 10cm from distally and proximally from perforation, colon was mobilisedupto hepatic flexure, right colic branches of superior Mesenteric artery were ligated Mesentery was ligated & cut n Resection done of distal ileum and lower 2/3rd of ascending colon, end to end anastomosis done using mersilk 3-0.

Mesentery was closed using vicryl 2-0, ADK drain no. 28 was kept in right paracolic gutter and fixed using ethilon 2-0.

Layerwise closure done, dressing done.

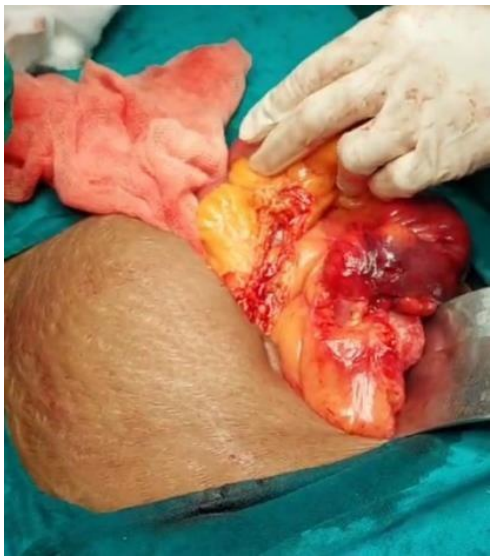
Post operative

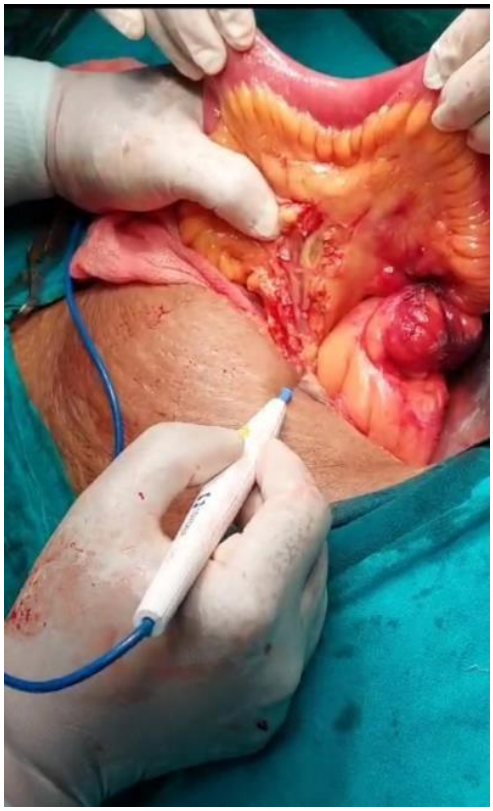
NBM, RT aspiration 4 hourly, IV antibiotics, IV analgesic, IV antacid, IV Antiemetic, IV fluids were administered.

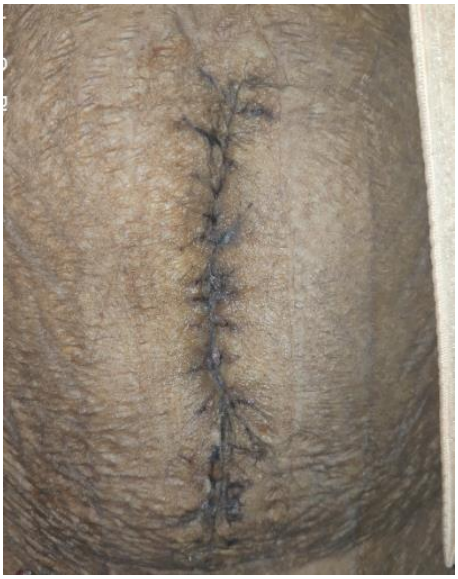
After surgery patient was kept NBM for almost 10 days in between wound gets infected as case

was infected, discharge from wound was sent for culture & sensitivity and corrugated drain was kept for drainage of that discharge. According to culture report IV antibiotics wereupgraded.

Patient get started loose motions at POD – 4, Patient land up into severe dehydration so totreat it Centraline was inserted & according to CVP fluid was given & I-O was maintained &CVP was maintained between 8-10.







In between PCV transfusion done, Albumin was replaced, electrolyte were corrected.

On POD – 09 patient was completely stable, ADK drain was removed, Ryles tube was removed, Centraline was removed, patient shifted on Full diet, wound was gaped so secondary closure was done on POD – 11th and corrugated drain was removed.

Due to loose motions hospital stay of patient was increased, stool routine, stool culture wasdone & accordingly treatment given with Lactobacillus supplement.

On POD – 19th patient was completely gets recovered & fit for discharge so patient was discharged with follow up adviced.

After 5 days patient came in OPd for follow, all stitches were removed & wound was completely healed.

Histopathological Report

Severe acute on chronic inflammation, ulceration, granulation tissue, congestion and perforation – consistent with gangrene of ileocecal junction.

Proximal and distal resection margins – unremarkable

Regional lymph nodes – 4/25 lymph nodes – Acute inflammation Rest of the lymph nodes – reactive lymphadenitis.

No. TB granuloma/ malignancy.

DISCUSSION

In patients who were on long term steroidal treatment, causes of acute abdomen getsdifficult to identified so early diagnosis is must.

This present a Diagnostic challenge in adult population with proper clinical and imaging work up. They can be managed effectively.

Ultrasound and CT scan are the imaging modalities to characterise the disease Patient has to manage surgically medically properly.

CONCLUSION

In this young female patient who takes steroids since 10 years was difficult to manage surgically & most imp in post operative recovery period was such a challenging condition.

But due to early or emergency surgical decision and proper medical management patient recovered within a month with too many post operative difficulties. But at the end patient gets completely recovered, this case may gets helpful for too many patients for early diagnosis and treatment.

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