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# Treatment of delayed jejunal perforation after irreducible femoral hernia repair with open abdomen management and delayed abdominal closure with skin flap approximation

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## ABSTRACT

**INTRODUCTION:** We show the management of a delayed jejunal perforation, after irreducible femoral hernia operation with the help of negative pressure therapy (NPT) and delayed abdominal closure (DAC) with skin flap approximation in an elderly woman for the first time in the literature.

**PRESENTATION OF CASE:** A 76 year-old woman was admitted to the emergency department with irreducible femoral hernia and ileus. After examining the femoral hernia sac and noting the presence of viable intestine within the hernia sac, a femoral hernia repair with mesh was performed. At postoperative day 1 she started to defecate and oral intake was started. The patient was discharged on postoperative day 3. On postoperative day 8, she was re-admitted to the emergency department with septic shock. The patient underwent reoperation. Septic abdomen and delayed perforation from strangulated part of the jejunum were seen. A jejunostomy was opened and patient was treated with open abdomen management and delayed abdominal closure with skin flap. The ostomy was closed 4 months later.

**DISCUSSION:** The exact mechanism of delayed presentation of small bowel perforation remains controversial. Delayed intestinal perforation has rarely been reported after blunt abdominal trauma (BAT), conductive burn injuries of the bowel with cautery, or necrosis of strangulated bowel in a hernia sac. Open abdomen (OA) management is a life-saving and challenging strategy in severe generalized peritonitis.

**CONCLUSION:** Delayed bowel perforation may develop after irreducible femoral hernia surgery. OA management with NPT and DAC with skin flap approximation are optimal treatment modalities for the hemodynamically instable patient.

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## 1. Introduction

Delayed bowel perforation has rarely been reported after blunt abdominal trauma (BAT), conductive burn injuries of bowel with cautery or necrosis of strangulated bowel in a hernia sac [1,2]. The exact mechanism of delayed presentation of small bowel perforation remains controversial. In a patient with BAT where the mesenteric injury is not severe and consists of only minor tears and contusions, the clinical presentation would follow a period of normal bowel function and may be delayed by a time period ranging from 2 weeks to 3 months. In the absence of a direct bowel injury, a patient may initially tolerate a diet and display normal bowel function [1]. Bowel perforations due to thermal injuries are fundamentally different from direct mechanical injuries. Contact burn

injuries from cautery may be recognized at the time of surgery and treated appropriately. In contrast, conductive burns are not recognized at all or are recognized when perforation occurs 1–3 weeks after the initial procedure [2]. Furthermore, the consequences of bowel injury can be catastrophic. A delay in diagnosis of bowel perforation can lead to sepsis, and even death, if not diagnosed and treated promptly [3].

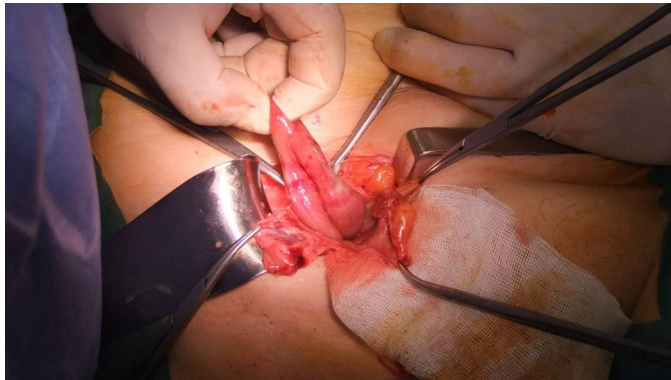
Open abdomen (OA) management is a life-saving and challenging strategy in situations such as abdominal compartment syndrome (ACS), damage-control surgery, and severe generalized peritonitis [4,5]. The OA is defined in the World Society of Abdominal Compartment Syndrome guidelines as one that requires a temporary abdominal closure due to the skin and fascia not being closed after laparotomy [6]. Mortality rates up to 50% were reported and were even higher in the infected OA [7,8]. Enteric fistulas are one of the most devastating abdominal complications in abdominal surgery [9].

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**Table 1**  
Laboratory value of patients before femoral hernia operation.

Biochemical analysis			Blood gas		
Glu	170 mg/dL	CRP	3 mg/dL (0–0.8)	pH	7.36
LDH	289 U/L	Sedimentation	46 mm	pCO <sub>2</sub>	26
Lipase	167 U/L	D-dimer	403 ng/mL (0–500)	PO <sub>2</sub>	78
Ure	174 mg/dL	Procalcitonin	0.313 ng/mL (<0.500)	HCO <sub>3</sub>	15
Creatinine	3.1 mg/dL	WBC	11,000 K/uL	BE	–7.7

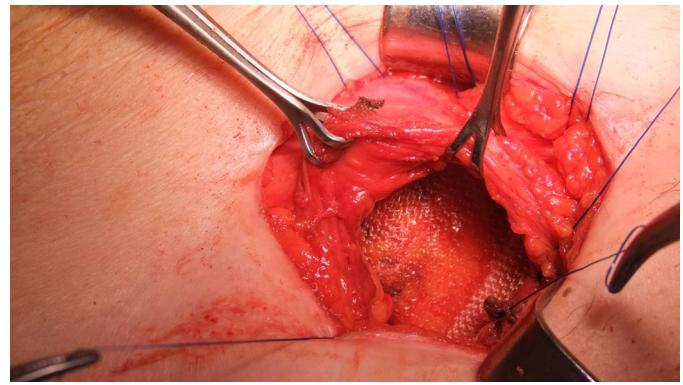
**Fig. 1.** Presentation of hernia sac and small intestine.

According to our knowledge, there is no report about delayed bowel perforation after the surgery of irreducible femoral hernia in the literature. Here, we report the management of a septic OA patient with the help of negative pressure therapy (NPT) and delayed abdominal closure with skin flap approximation in a 76-year-old woman with delayed jejunal perforation, 8 days after irreducible femoral hernia operation.

## 2. Presentation of Case

A 76-year-old woman was admitted to the emergency department with complaints of abdominal pain, constipation, vomiting, anuria and shortness of breath. The patient reported abdominal pain especially on the right inferior part of abdomen that had been present for a long time. The severity of the pain had increased in the last 2 days. Comorbidities included hypertension, diabetes, hyperlipidemia, coronary arterial disease and chronic obstructive lung disease. A previous abdominal operation for a perforated appendix occurred 15 years prior. Upon physical examination, the patient's blood pressure (BP) measured 105/55 mmHg, heart rate (HR) was 96, and temperature was 36.9 °C. The abdominal examination revealed hyperactive bowel sounds and minimal distention. Sensitivity and rigidity were observed in the right inferior quadrant of abdomen. An irreducible femoral hernia was present on the right side of the abdomen. Prerenal acute renal failure and mild metabolic acidosis were present (Table 1). X-rays showed the abdominal air/fluid level.

Consultation with cardiology, internal medicine, endocrinology and anesthesia was performed, and the patient hydrated during this period. During a 3-h period following hydration, urine output was measured at 200 cc; 1400 cc of small intestinal contents were drained via nasogastric tube. The patient underwent an emergency operation for irreducible femoral hernia. The hernia sac and small intestine were isolated, and the small intestine was thought to be viable (Fig. 1). The abdomen was explored from femoral defect after dilating this opening. There was only serous fluid was present without any other pathology. Femoral hernia repair was performed by preperitoneal mesh insertion (Fig. 2), as Yetişir previously described [10]. The patient started to defecate on postoperative day 1, and oral intake was initiated. On postoperative day

**Fig. 2.** Mesh was placed under the fascia and over the peritoneum after preperitoneal preparation from dilated femoral opening.**Table 2**  
Laboratory value of the patients 3 days after the femoral hernia operation.

Biochemical analysis		Total blood count	
Glu	100 mg/dL	WBC	7000 K/uL
LDH	259 U/L		
Lipase	60 U/L		
Ure	104 mg/dL		
Creatinine	0.9 mg/dL		

**Table 3**  
Laboratory value of the patients 8 day after femoral hernia operation.

Biochemical analysis			Blood gas		
Glu	140 mg/dL	CRP	18.4 mg/dL (0–0.8)	pH	7.3
LDH	.357 U/l	Sedimentation	55 mm	pCO <sub>2</sub>	32
Lipase	251 U/L	D-Dimer	5017 ng/mL (0–500)	PO <sub>2</sub>	58
Amylase	253 U/L	Procalcitonin	8.55 ng/mL (<0.500)	HCO <sub>3</sub>	16
Ure	115 mg/dL	INR	1.55	BE	–8
Creatinine	1.2 mg/dL	WBC	22,000 K/uL	Lac	4.1
Alb	1.55 g/dL				
T. protein	3.5 g/dL				

3, the general condition of patient was well; she was conscious and oriented. Prerenal acute renal failure had improved (Table 2), and the patient was discharged from hospital.

The patient was readmitted to the emergency department with the complaint of abdominal pain, vomiting, anuria and shortness of breath on postoperative day 8. Her general condition, consciousness and orientation were not well. In physical examination, her BP measured 80/55 mmHg, HR was 114, respiratory rate was 36, and temperature was 38 °C. The patient's intra-abdominal pressure (IAP) was 18 mmHg. On her abdominal examination, there were no bowel sounds or distention. The patient was in septic shock and metabolic acidosis. D-Dimer was high (Table 3), and the white blood cell count (WBC), c-reactive protein (CRP), procalcitonin, and lactate levels were increased (Figs. 3 and 4). Air/fluid levels in the small bowel and intra-abdominal fluid collection were present in the abdominal computerized tomography (CT) scan (Fig. 5). The sequential organ failure assessment score (SOFA) of the patient was 15, and her estimated mortality was 80%. The patient was selectively intubated, Clexane 2 × 0.6 was administered, and antibiotic therapy was started. Fluid and electrolyte resuscitation and low vasopressor support were started. The patient underwent an emergency operation where 2–3 liters of enteric influents were present and all intestinal tissue was very edematous and fragile during exploration. The patient's open abdomen classification was 2C according to the new Björck score (Fig. 6). All intra-abdominal content was washed and irrigated with saline. After gentle dissection, a perforation point of jejunum 150 cm from the ligament

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