CASE REPORT – OPEN ACCESS

International Journal of Surgery Case Reports 36 (2017) 136–139

Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.casereports.com

Ileo-ileal intussusception of a sutured enterotomy site, 6 days after laparotomy due to fetobezoar: A case report

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ARTICLE INFO

Article history:
Received 4 March 2017
Received in revised form 3 May 2017
Accepted 6 May 2017
Available online 15 May 2017

Keywords:
Postoperative
Intussusception
Small bowel obstruction
Enterotomy
Case report

ABSTRACT

INTRODUCTION: Postoperative small bowel obstruction due to intussusception is a rare entity but can lead to severe morbidity and even mortality. We present a case of this rare complication produced by an unusual cause.

CASE REPORT: A 22 year old male, who is a fruitarian, presented to the E.R on day 6 after laparotomy due to obstructing fetobezors that were removed via gastrotomy and enterotomy. In his readmission, he had severe, diffuse abdominal pain, distended abdomen and diffuse peritonitis. Abdominal computed tomography (CT) showed a large amount of fluid in the abdomen, distended small bowel loops, a small amount of free air around the stomach and a suspected ileo-ileal intussusception. The patient underwent emergent laparotomy which revealed an ileo-ileal intussusception with the sutured enterotomy site from the previous operation as the lead point. In addition, a minor dehiscence of the gastrotomy site was identified. A reduction of the intussusception was performed with resection of the enterotomy site and side to side anastomosis. The gastrotomy site was debrided and re-sutured. Recovery was uneventful.

CONCLUSION: Postoperative intussusception, although rare, is potentially a dangerous complication, often not involving the site of the primary operation. To our knowledge this is the first report of an intussusception with a sutured enterotomy site as the lead point. Clinicians should be aware of this entity when assessing a patient with abdominal pain and distention after surgery with enterotomy or resection of bowel.

1. Introduction

Intussusception is a rare cause of bowel obstruction in adults accounting for 1%-5% of bowel obstructions [1]. It is commonly associated with an organic cause, however up to 20% may be idiopathic. Postoperative intussusceptions are a very rare entity and described mostly after manipulation of the stomach and proximal jejunum [2,3].

We present a case of an antegrade intussusception with a sutured enterotomy site as a lead point at POD 6.

This case was managed at Meir Medical Center, a public academic institute.

2. Case report

A 22 year old male presented to the E.R with a three day history of vomiting and abdominal pain. The patient is a fruitarian (a person whose diet consists chiefly of fruit [4]) and reported eating 20 persimmons the day before onset of symptoms. He had no surgical history.

Abdominal X-rays and CT showed small bowel obstruction with suspected bezoars in both ileum and stomach. An attempt to extract the stomach bezoars via endoscopy failed and the patient underwent a laparotomy. Three large fetobezoars were extracted from the stomach through a gastrotomy in the anterior stomach wall. Another fetobezoar was extracted from the ileum through a longitudinal enterotomy which was then sutured horizontally. Both the gastrotomy and enterotomy were sutured in double layers. A thorough scan of the small bowel was performed and no additional fetobezoars were found.

Recovery from the operation was uneventful; however the patient continued to consume only fruit, and since he was advised against a high fiber diet, restricted himself to filtered juice. Psychiatric evaluation did not reveal any major pathology. The patient was discharged on postoperative day 5.

24 h later the patient returned to the E.R with vomiting, severe abdominal pain, hypothermia and a distended and tender abdomen. Abdominal X-rays demonstrated small bowel obstruction. CT revealed a large amount of fluid in the abdomen, a small amount of free air around the stomach and distended small bowel loops with a transition zone near the ileocecal valve (Fig. 1). Sus-

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http://dx.doi.org/10.1016/j.ijscr.2017.05.015

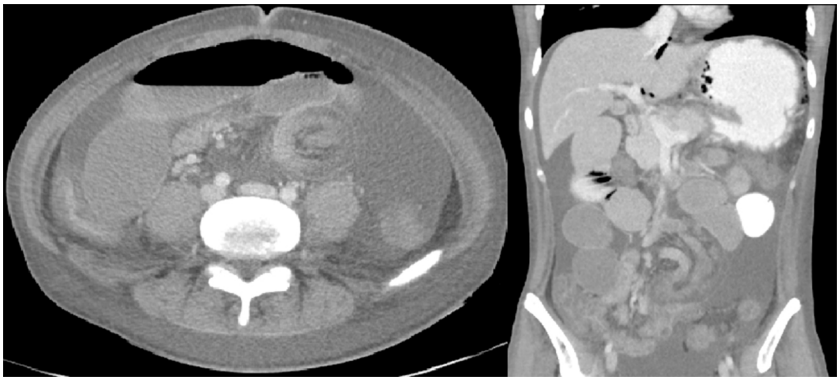

Fig. 1. Abdominal CT showing intussusception.

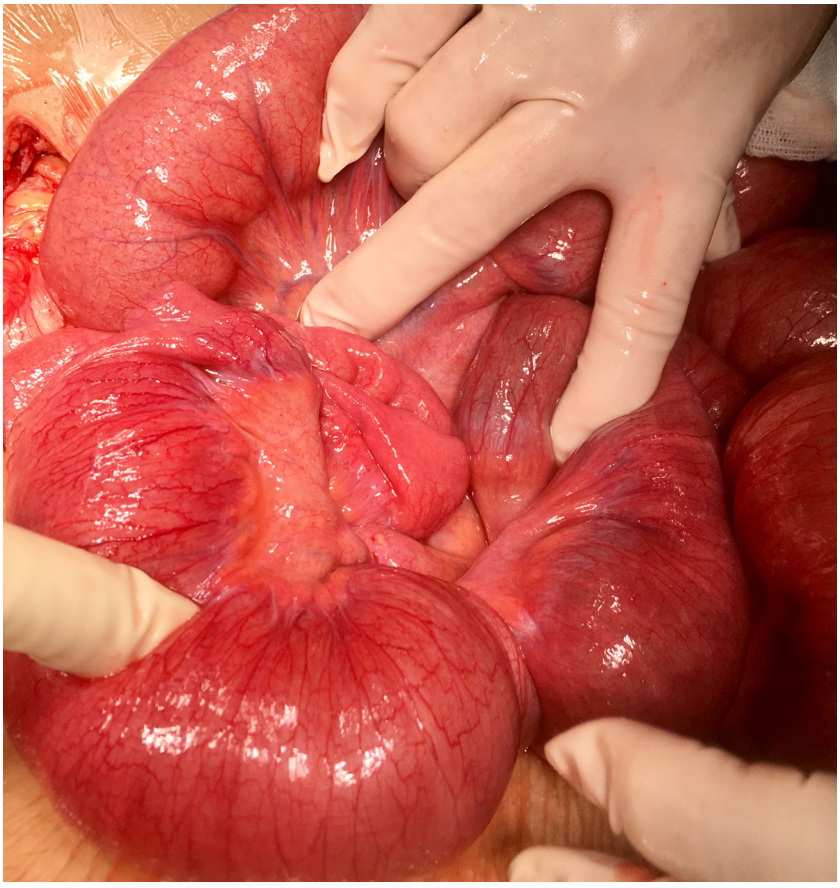

Fig. 2. Antegrade intussusception of ileum.

picion of an intussusception was raised however the presence of another fetobezoar could not be ruled out.

An emergent exploratory laparotomy was performed. An antegrade intussusception of the ileum (Fig. 2) and a two millimeter dehiscence of the gastrotomy site were found. A decompression of the intussusception was carefully performed. The length of the intussusceptum was roughly 50 cm with the lead point being the enterotomy site from the previous laparotomy. There was no leak from the enterotomy suture line; however the enterotomy site seemed to be mildly edematous (Fig. 3). Examination of the formerly invaginated bowel loop showed moderate hyperemia with good peristalsis and pulse. It was restored into the abdomen and care was then taken to repair of the gastrotomy site, which was debrided and resutured in two layers. Re-examintaion of the previously invaginated segment of small bowel showed it had recovered well after decompression, and so only 10 cm of small bowel, enterotomy site included, were resected. Side to side hand sawn anastomosis was performed.

The patient's postoperative course was characterized by a slow recovery, requiring parenteral nutrition which was complicated by re-feeding syndrome and the need for intravenous replacement therapy. After initiating a vegan diet the patient was discharged on the seventh day following his second operation.

Pathology report of the resected small bowel loop showed inflammatory changes with no other pathologic findings.