Burst Abdomen Complicated By Ileo-Ileal Intussusception In A Post-Myomectomy Nigerian Woman – Report Of A Case

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INTRODUCTION

Burst abdomen is a rare emergency in surgical practice with known aetiologic factors. Its occurrence is dreaded not only by the patient but also frightening to by-standers alike. On the other hand, intussusception which usually entails telescoping of the proximal part of the intestine into a distal segment, is commoner in children in the ileal region. In children it is usually benign and without a lead point. In adults, the ileo-ileal type is rare.

CASE REPORT

A 32-year old Nigerian woman was referred to the surgical unit having developed a complete wound dehiscence with evisceration in the ward while attempting to see-off relatives that came visiting (Figure 1). Prior to this episode, she had a conventional open myomectomy six days earlier. No history of chronic constipation, diarrhea, cough, abdominal distention or use of enemas. She had commenced oral feeds on the third post-myomectomy day and was being scheduled for discharge on the seventh post-operative day when she developed the burst abdomen on the sixth day.

Examination revealed an anxious-looking woman, not pale and not dehydrated or febrile. The vital signs were stable. The abdomen showed a complete wound dehiscence with evisceration of the small bowel and omentum (Figure 1). The post-operative notes indicated that the gynecologist closed the fascia with chromic 1 catgut using a continuous suturing technique. The patient had saline-soaked gauze dressing applied over the eviscerated bowel loops and was prepared for immediate closure.

Figure 1

A 32-year old Nigerian woman with a burst abdomen post-myomectomy

At surgery, a formal exploration was done after copious
irrigation of the eviscerated bowel loops. An ileo-ileo-intussusception was noted 45cm from the ileocecal junction with 22cm bowel loop already telescoped (Figure 2).

**Figure 2**
Ileo-ileo-intussusception 45cm from ileocecal junction with 22cm bowel loop already telescoped. Note the left hand on the lead point.

The intussusception was reduced in the usual fashion and the abdomen closed with monofilament nylon 1 suture using the continuous mass closure technique with vicryl 3/0 subcuticular stitches applied to the skin.

**RESULTS**
The patient did well and was discharged on the seventh post-operative day. She was followed up for one year in the outpatient department without any evidence of recurrence.

**DISCUSSION**
Burst abdomen occurs in 1% of all abdominal operations with 10% mortality. Its peak incidence occurs between 6th and 8th postoperative day. The predisposing factors are well documented and classified into pre-operative (patient

**CONCLUSION**
There is the need to look out for untoward bowel pathologies, that may coexist, when working in the pelvic region. This will obviate the need for re-opening of the patient, the attendant complications and psychological challenges. All attempts must be made to avoid the predisposing factors to burst abdomen particularly the surgeon

**References**
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