

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

E E Akpo

Citation

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Abstract

Background: Burst abdomen is a rare emergency with known attributable causal factors. However, ileo-ileal intussusception complicating a burst abdomen following a myomectomy has never been reported in the world literature. This paper presents the case of a burst abdomen complicated by ileo-ileal intussusception in a post-myomectomy patient.

Case Report: The case of a 32-year old Nigerian woman who had a conventional open myomectomy, developed a burst abdomen coexisting with intussusception is presented.

Results: The patient did well after reduction, discharged from hospital after six days and followed-up for one year with no evidence of recurrence.

Conclusion: Vigilance on the bowel while working in the pelvic region is recommended. Additionally, predisposing factors to burst abdomen should always be prevented particularly the surgeon's factors.

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-ileal intussusception was noted 45cm from the ileocecal junction with 22cm bowel loop already telescoped (Figure 2).

Figure 2

Ileo-ileal 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 out-patient 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

1. Akhator A, Osime C. Colocolonic intussusception in an adult being prepared for bowel resection – a rare form of presentation. *Biosci., Biotech. Res. Asia* 2009; 6(2): 551-553.
2. Al-Fallouji MAR and McBrien MP. Abdominal wound dehiscence in Postgraduate Surgery, the candidate's guide. 1st Ed. Butterworth-Heinemann Ltd. 1993. pp. 31-33.
3. Law HL, Aidreto JS. Small bowel obstruction: a review of 465 cases. *South Med J.* 1976; 69: 733-734.
4. Agha FP: Intussusception in adults. *AJR Am J Roentgenol* 1986, 146:527-31.
5. Schuld Y, Van Gansboke D, Ansay J. Intussusception in adults. *Acta Chir Belg.* 1985; 85(1):55-60.
6. Weillbaecher D, Bolin JA, Hearn D, Ogden W: Intussusception in adults. Review of 160 cases. *Am J Surg* 1971
7. Azar T, Berger DL: Adult intussusception. *Ann Surg* 1997, 226:134-8.
8. Barussaud M, Regenet N, Briennon X, de Kerviler B, Pessaux P, Kohneh-Sharhi N, Lehur PA, Hamy A, Leborgne J, le Neel JC, Mirallie E: Clinical spectrum and surgical approach of adult intussusceptions: a multicentric study. *Int J Colorectal Dis* 2006, 21(8):834-9.
9. Soni S, Moss P, Jaiganesh T. Idiopathic adult intussusception. *International J. of Emergency Medicine* 2011, 4:8
10. Jeremko JL, Rawat B, Colo-colonic intussusception caused by a solitary Peutz-Jegher's polyp. *The British J. Radiology* 2005; 78:1047-1049.
11. Huang BY, Warshauer DM: Adult intussusception: diagnosis and clinical relevance. *Radiol Clin North Am* 2003, 41(6):1137-51.
12. Williams H: Imaging and intussusception. *Arch Dis Child Educ Pract Ed* 2008, 93:30-36.

Author Information

E. E. Akpo, MBBS; FMCS; FICS; FMAS; DMAS; FIHA Consultant General and Minimal Access Surgeon

Delta State University Teaching Hospital

Oghara, Delta State, Nigeria

marieakpo@yahoo.com