Case presentation
A rare case of acute intestinal obstruction secondary to internal hernia

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First year PG

General Surgery

Chief complaints:

An otherwise healthy 15 year old girl presented to causality with complaints of pain in right iliac fossa since 2 days.

2 episodes of non bilious vomiting and fever since 1 day.

Presenting illness:

Pain was acute in onset in right iliac fossa and gradually increased.

Pain was Intermittent and severe.

Constipation since 3 days and 2 episodes of vomiting

She suffered similar complaints one year ago and was treated at a local hospital symptomatically.

Past history:

Not a known case of Diabetes mellitus, tuberculosis, bronchial asthma.

No history of previous surgeries.

Gynecological history:

Attained menarche at age of 13

Menstrual cycle 4/30

No pain, no clots, no excessive bleeding.

Personal history:

Appetite : normal

Bowel and bladder : normal

Sleep :adequate

All vaccinations given as per schedule.

On examination

Patient is thin built, moderately nourished.

No icterus, pallor, cyanosis

Pulse : 115 bpm

Blood pressure : 90/60 mm hg

Temp: 100˚F

CVS: S1S2 heard

Resp: BAE +

Per Abdomen:

- **Inspection**:

❑Distended

❑No fullness in the flanks

❑Umbilicus inverted

❑No engorged veins seen

- **Auscultation** :

❑Bowel sounds absent

- **Palpation :**

❑Soft

❑Guarding present

❑Tenderness all over abdomen.

❑Rebound tenderness in RIF and LIF

❑No mass palpable.

- **Percussion:**

❑No shifting dullness

❑Tympanic sound in upper abdomen and dull note in lower abdomen

❑Liver dullness not obliterated

Per rectum:

- ❑ No fecal impact
- ❑ Collapsed rectum

After inserting naso-gastric tube, Foleys catherization and iv fluids following investigations were done.

	labarotary parameters
Hemoglobin	**11.5g/dl**
TLC	**15000/cc**
Urea	**21mg/dl**
Creatinine	**0.58mg/dl**
S.Na^+	**135mEq/l**
S.K^+	**3.8mEq/l**
S.Amylase	**28IU/L**

Chest X-RAY : normal

X-Ray Erect abdomen showed 3 air fluid levels.

USG abdomen revealed free fluid in abdomen and pelvis, inflamed cecum, dilated bowel. Appendix was not visualized.

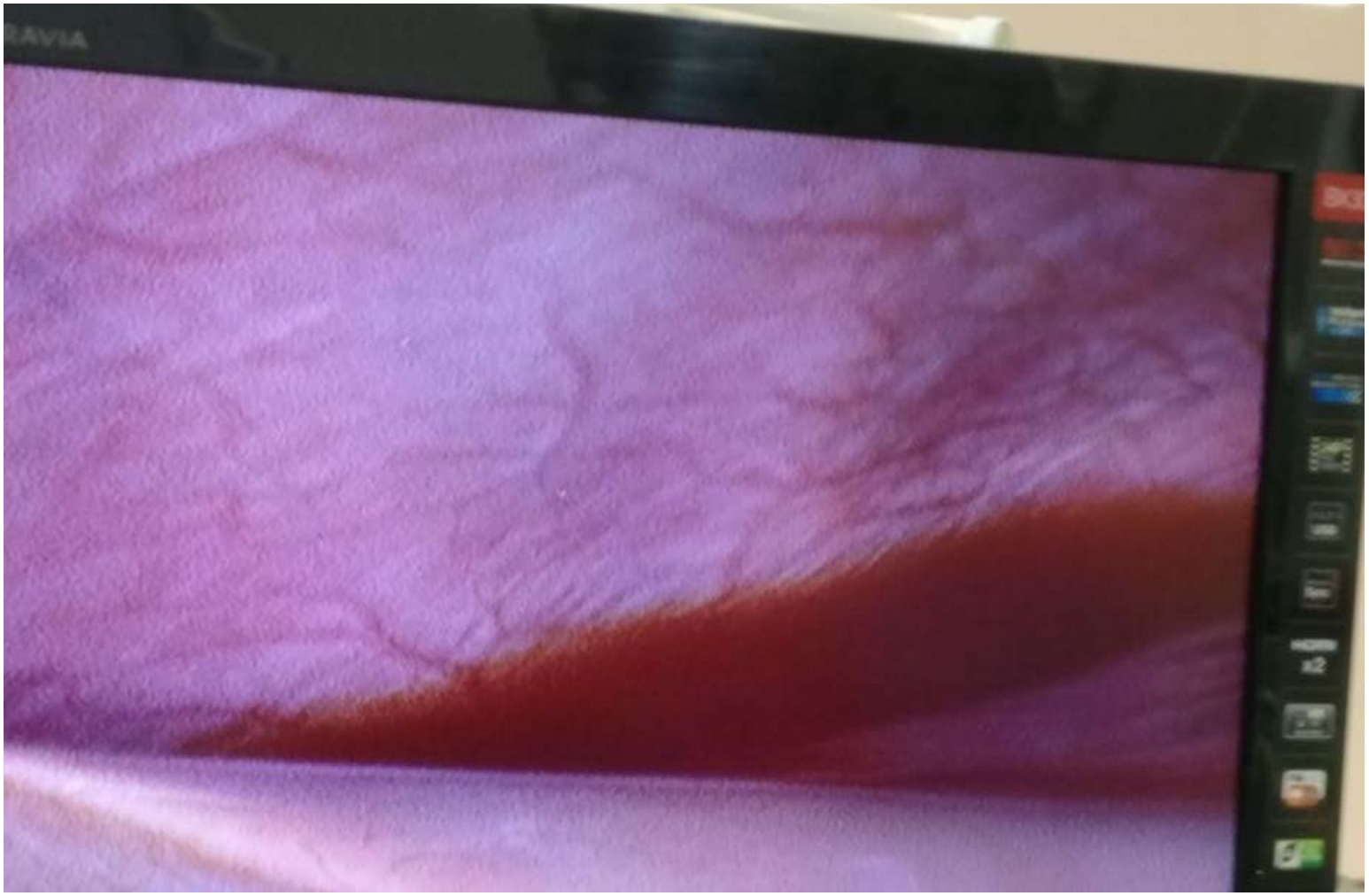
Considering her age CT was avoided and diagnostic laparoscopy and proceed was planned.

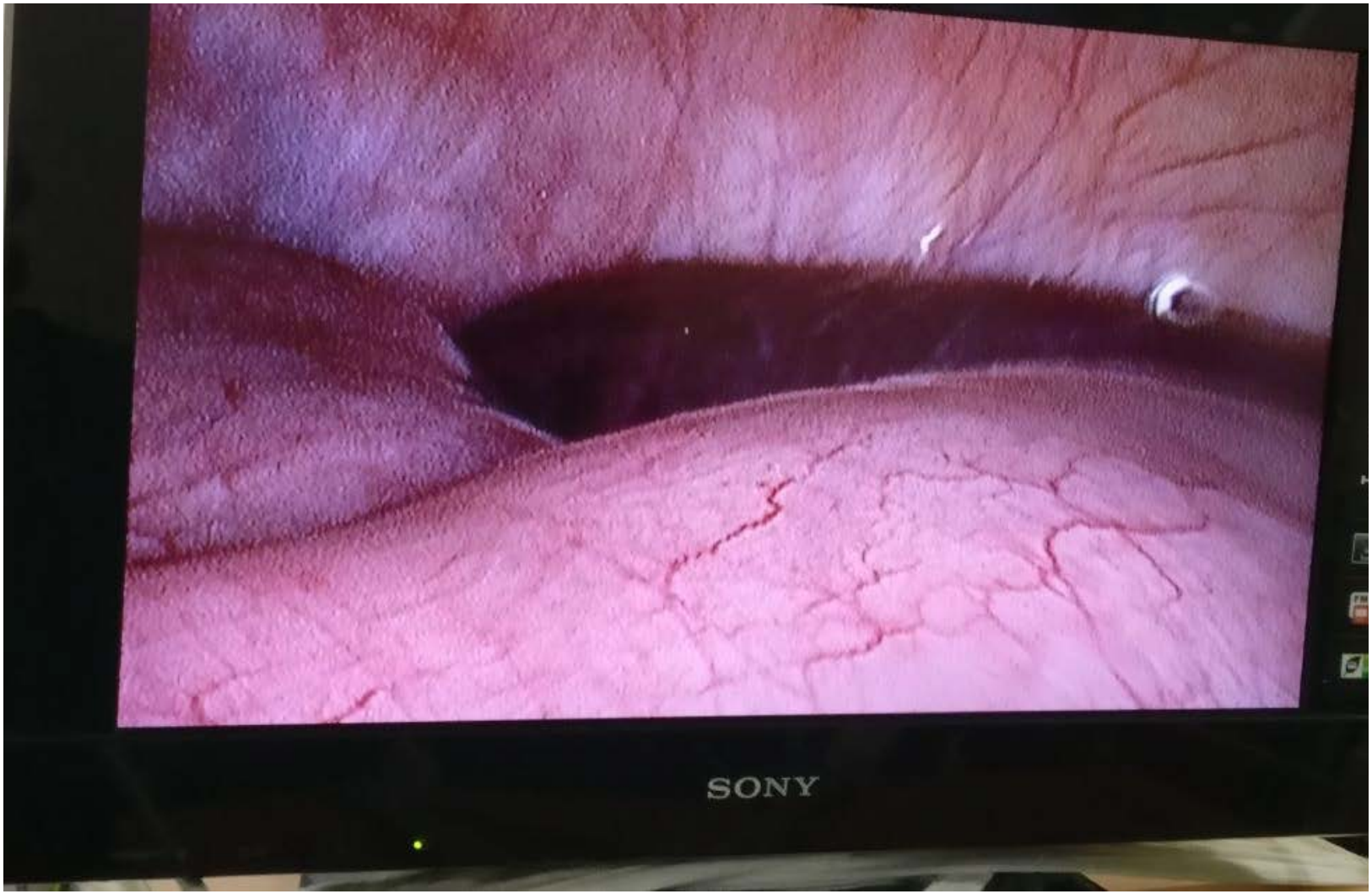
Diagnostic laparoscopy showed

- Moderate quantity of high coloured fluid
- Dusky loops of small bowel

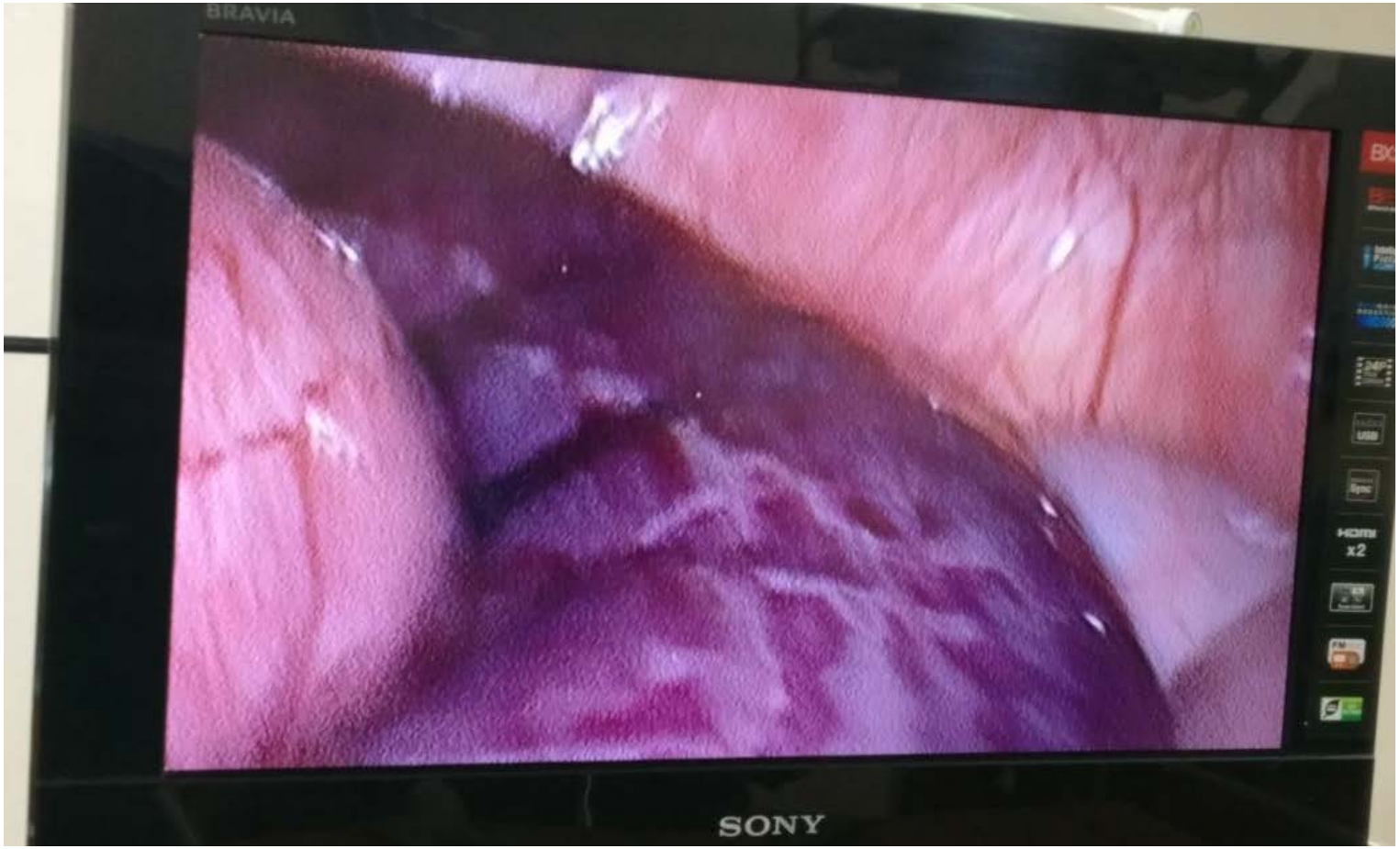
Hence decision was taken to do open laparotomy.

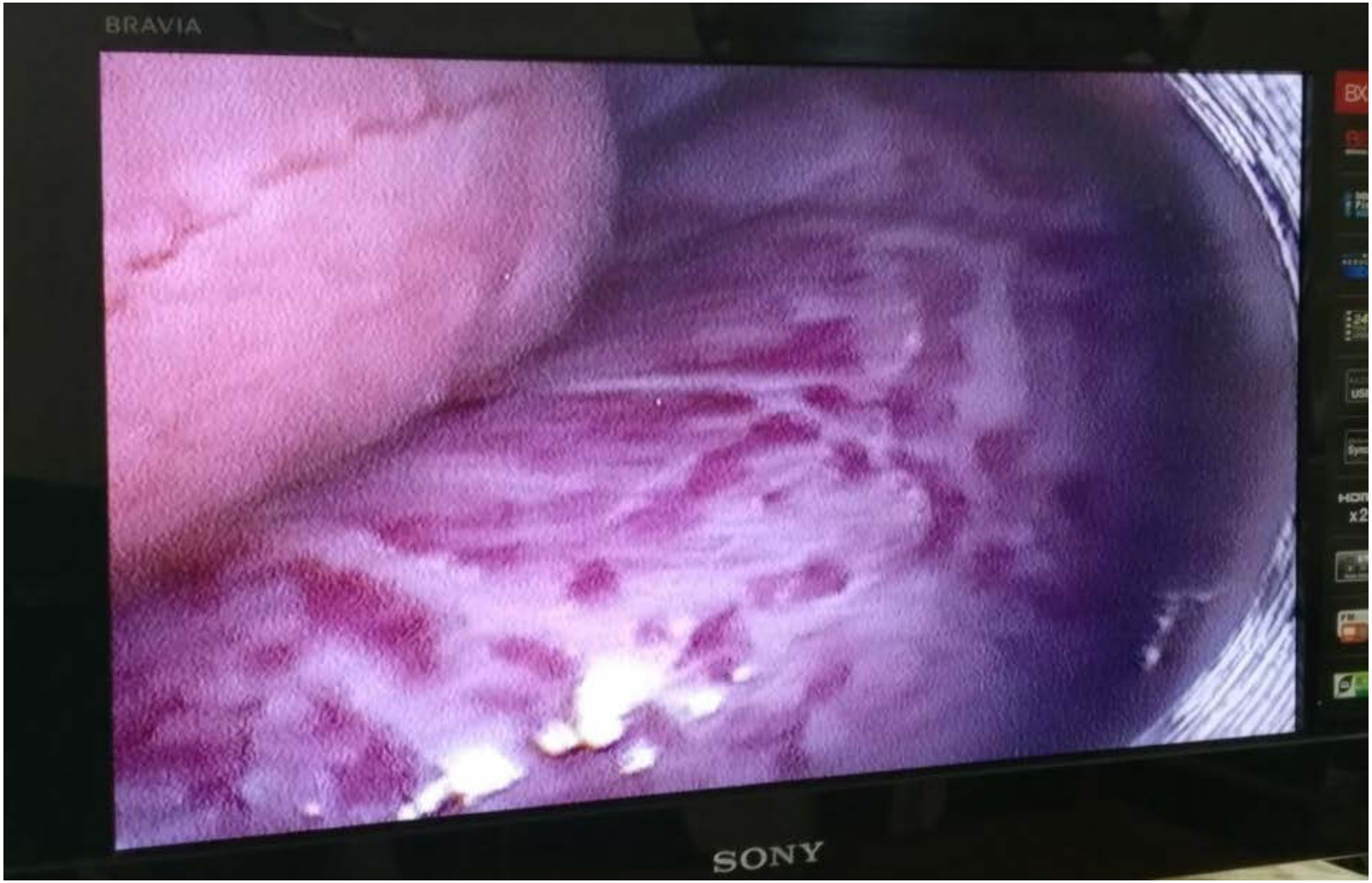
High colored fluid




SONY

Dusky loop of small bowel




BRAVIA
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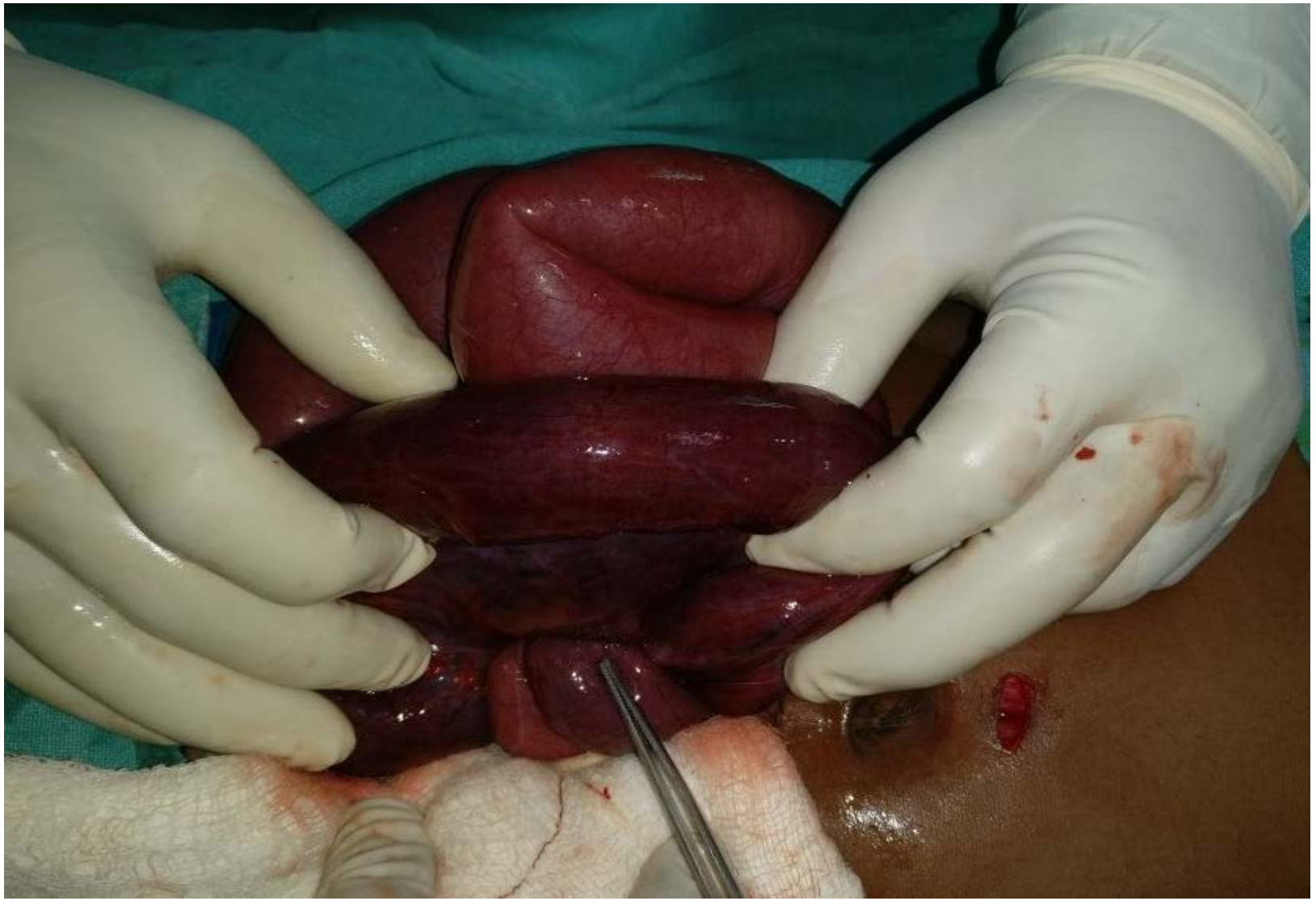
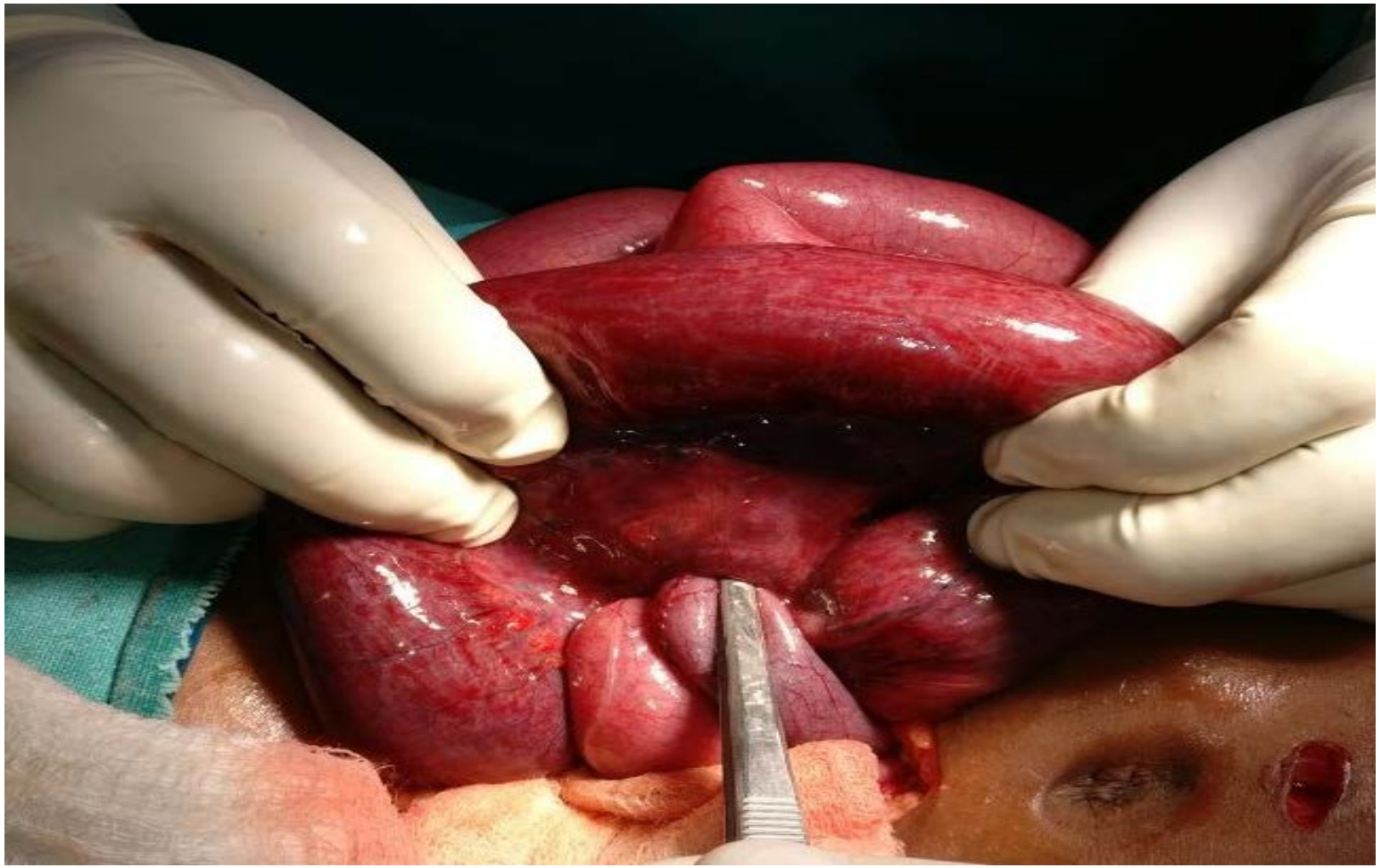
Mid line incision was given, 500ml-700ml of reactionary fluid was drained.

Part of proximal ileum and cecum along with appendix was herniated into large mesenteric defect located in the distal ileum.

Herniation of bowel



Afferent and efferent bowel loops



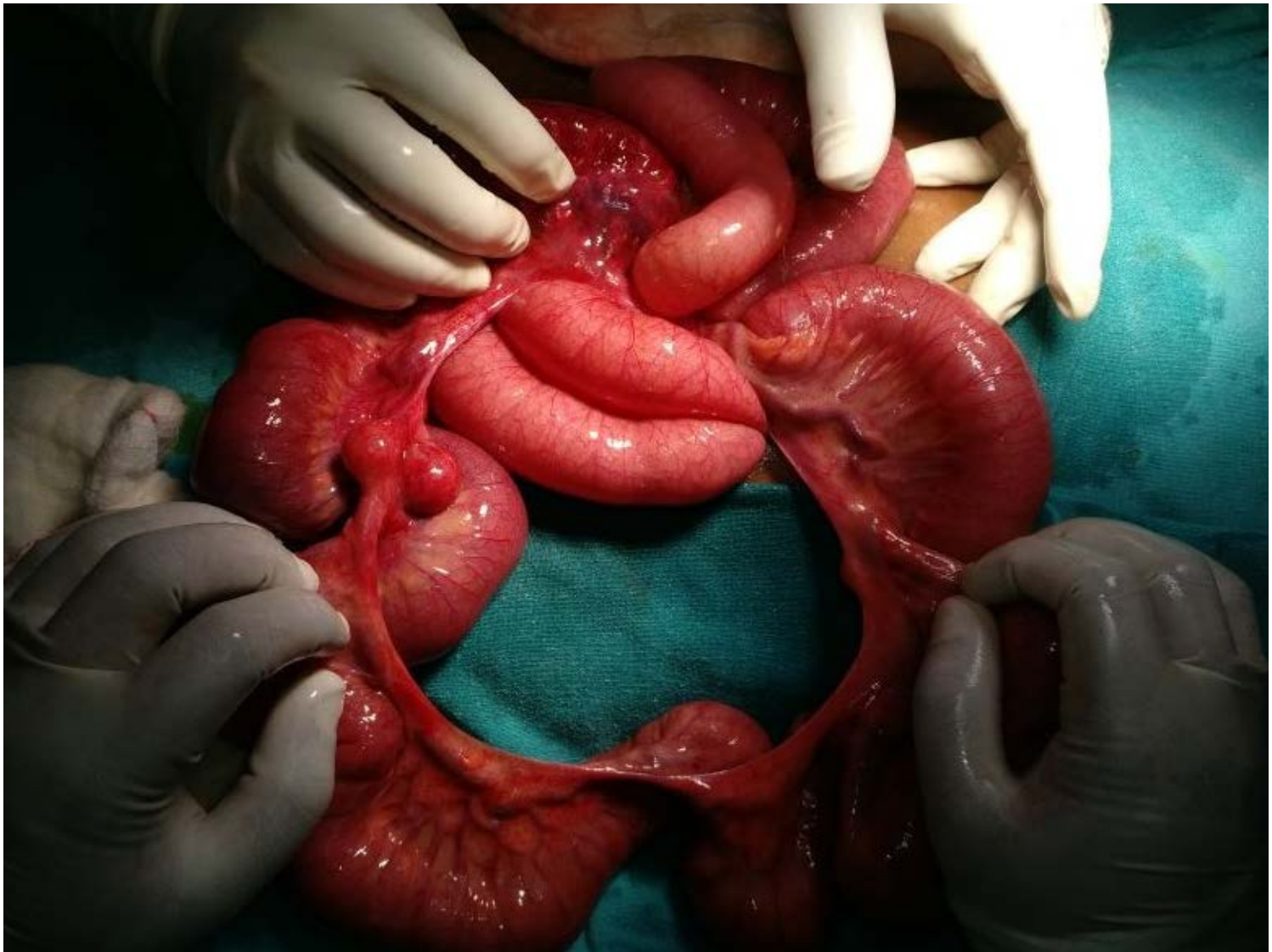
After reducing the hernia 100% oxygen was given and warm mops were applied over the bowel.

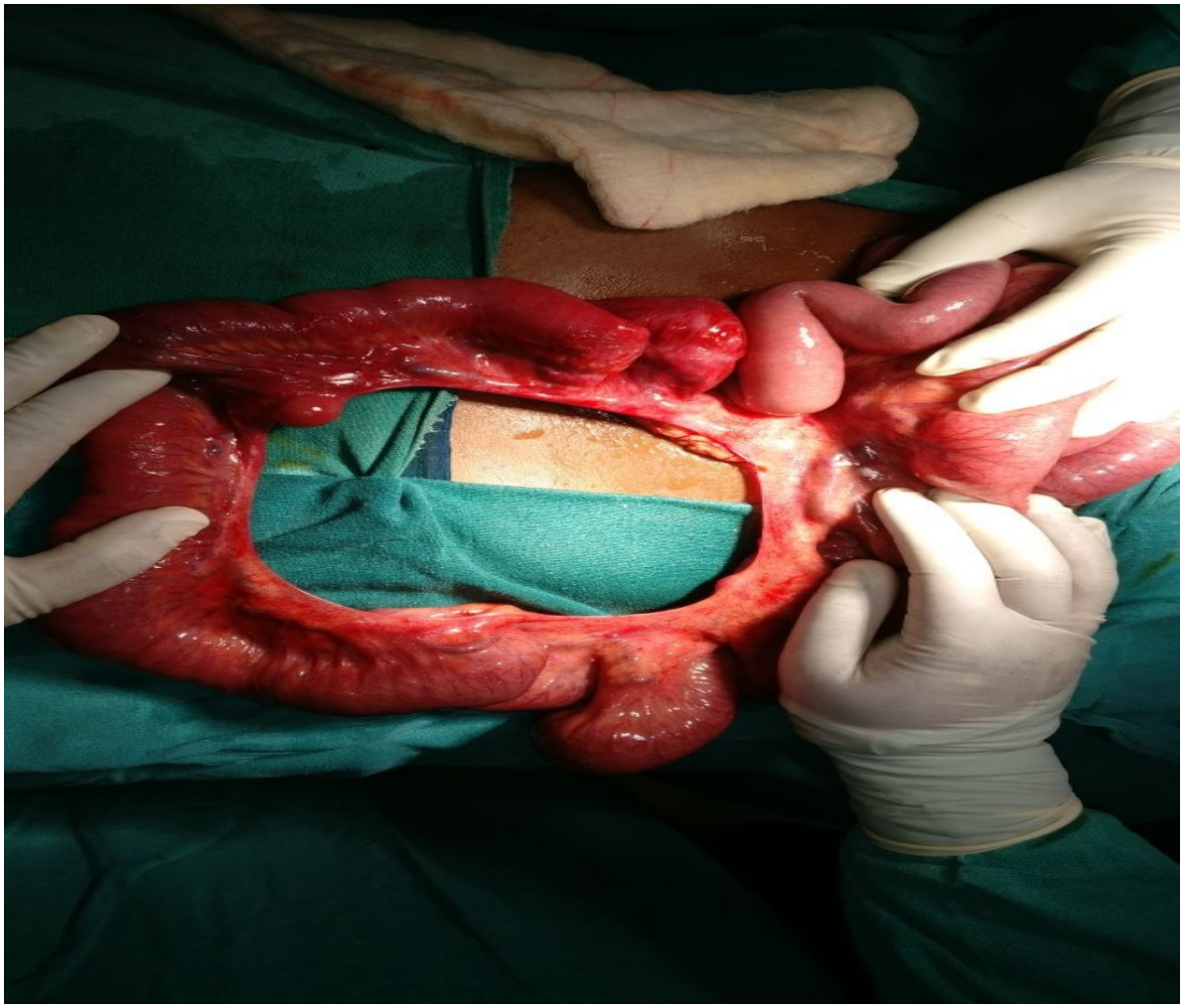
Bowel attained its normal blood supply and color change was observed.

Mesenteric defect around 15X12 cms was noted.

Along the mesenteric border dilated veins with thrombus were identified.

Defect in mesentry

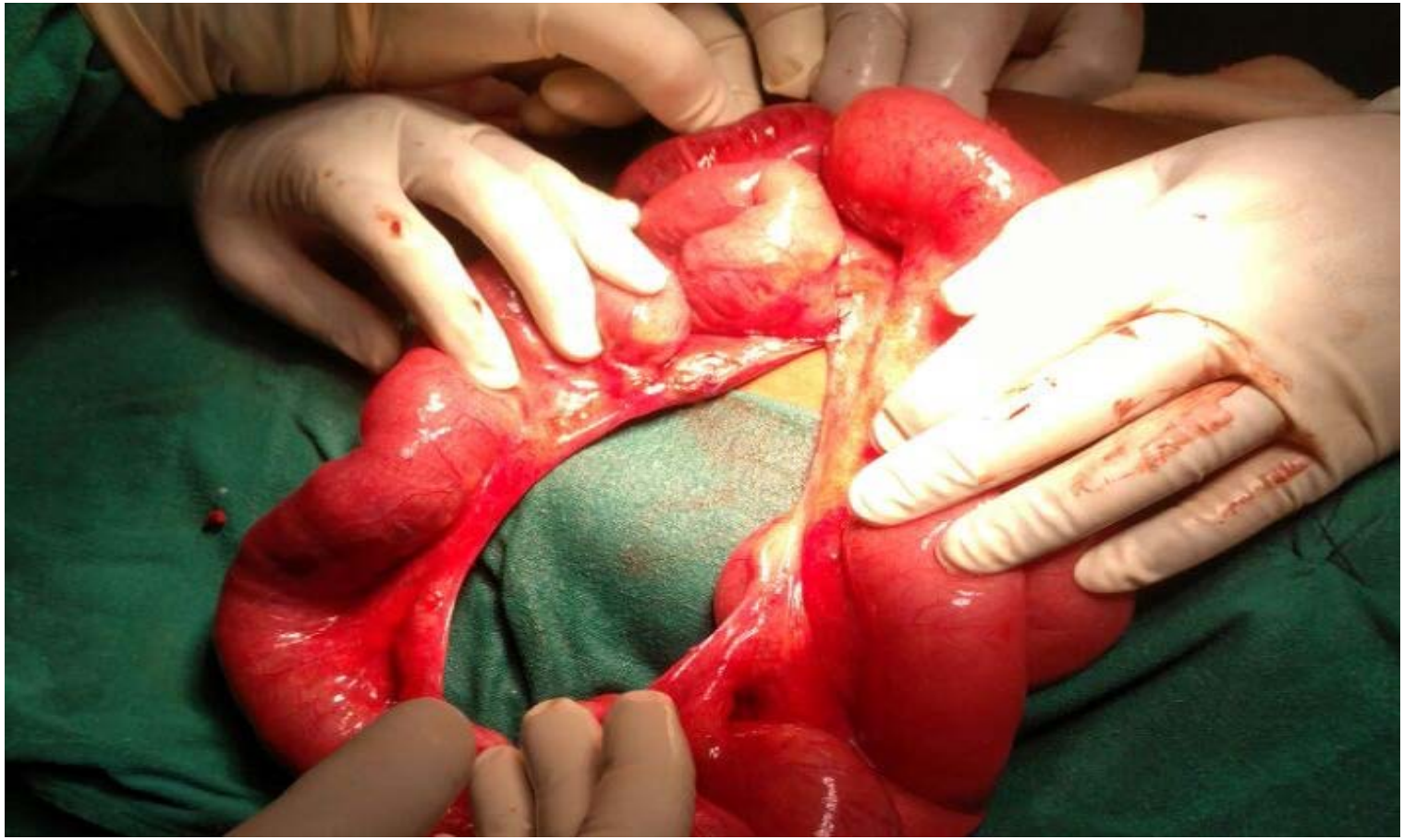


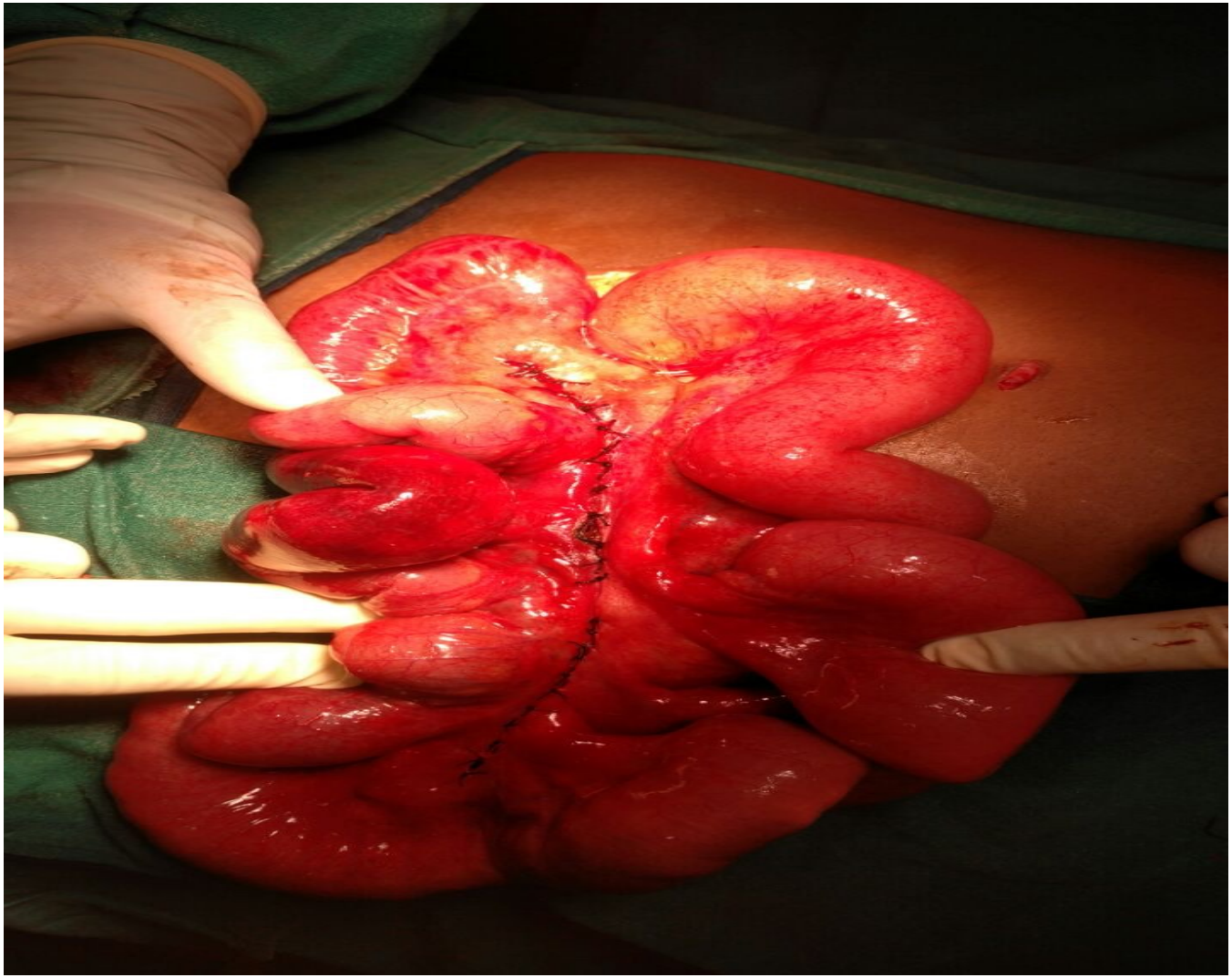


Rest of the bowel was inspected and appeared normal.

Through wash was given and approximation of the mesenteric defect was done with 2.0 Silk.

Approximation of defect





Patient was kept NBM for 48 hours and started with oral liquids to soft and normal diet in due course.

She attained bowel movements after 72 hours and recovered well.

Post op period was uneventful and she was discharged after 12 days.

Follow up visits for 3 months were done and had no complaints.

Thank you