



Necrotic Sigmoid Volvulus Of The Postpartum Period

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ABSTRACT :

Postpartum sigmoid volvulus is rare with less than 80 cases reported in the literature. We report a case of postpartum sigmoid volvulus that occurred at the fifth day of a caesarean section for non-reassuring fetal status in a 35-year-old primigravida who presented with an acute surgical abdomen. An exploratory laparotomy revealed a necrotic volvulus of the sigmoid colon and upper rectum. This is a diagnosis not to be missed in the postpartum period

INTRODUCTION

volvulus is a rare complication of pregnancy. It is said to be the second most common cause after occlusions on bridges. Its diagnosis is difficult and its prognosis is linked to the precocity of its management [1]. We report the observation of a patient, admitted for occlusive syndrome on day 5 of a caesarean section for non-reassuring fetal condition.

PATIENT AND OBSERVATION

Mrs KA, 35 years old, primigravida primiparous without any pathological history, admitted at D5 of a caesarean section at term for non-reassuring fetal state in a context of gravidic hypertension giving birth to a female newborn Apgar 9/10 birth weight 3200g for abdominal distention with cessation of feces and gas.

Physical examination revealed an altered general condition with a fever of 38.5°C, blood pressure of 100/60 mmHg and a pulse of 110bpm. Abdominal examination revealed abdominal distention with generalized tenderness. On rectal examination, the rectal ampulla was empty.

The unprepared abdomen (UAP) showed very significant colonic distension (Figure 1).

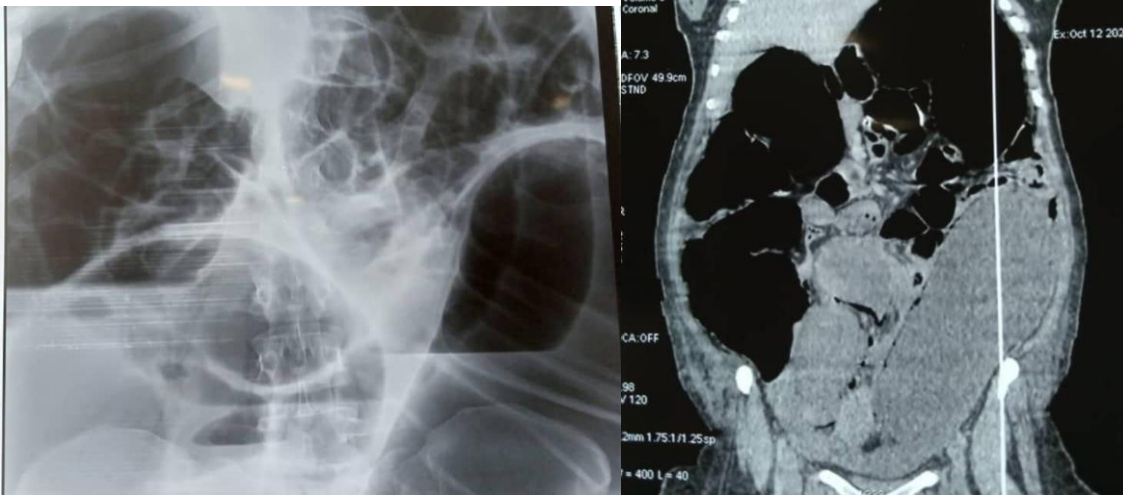


Figure 1 UAP showed very significant colonic distension

Figure 2 scan showed significant digestive distension with stercoral stasis

Abdominopelvic CT scan showed significant digestive distension with stercoral stasis associated with intraperitoneal effusion (Figure 2). The biological work-up showed a hyperleukocytosis of 19,000 elements/mm³.

The diagnosis of peritonitis on sigmoid volvulus was retained, and a surgical exploration was indicated. After a median laparotomy, a medium-sized purulent effusion with false membranes and a clockwise sigmoid volvulus with sigmoid necrosis extending to the upper rectum were found (Figure 3).

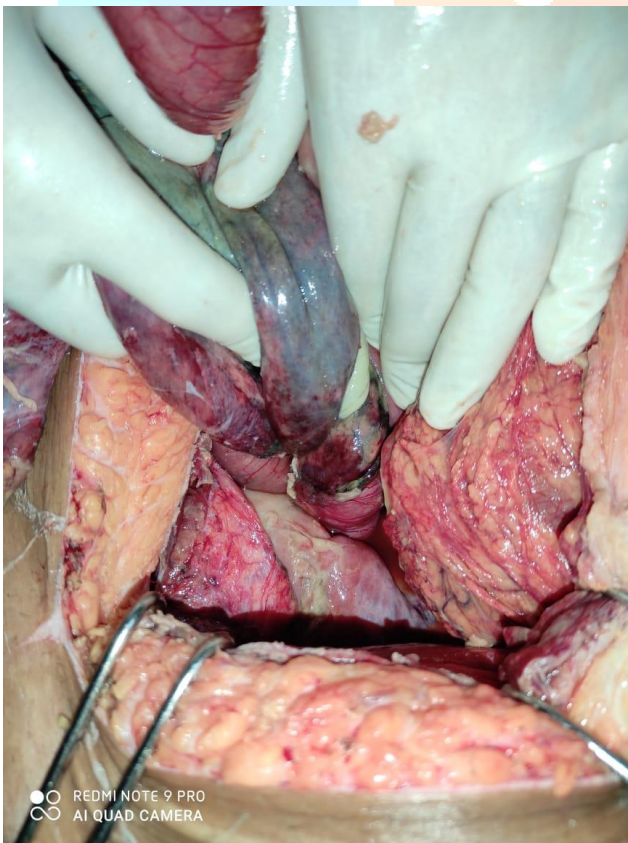


Figure 3 : sigmoid volvulus with sigmoid necrosis



Figure 4: segmental colorectal resection

We performed a segmental colorectal resection and a left colostomy. (Figure 4).

Discussion

Sigmoid volvulus is commonly reported in elderly patients with a high incidence in Africa has been attributed to the high vegetable fibre diet in this population [2].

Common causes of bowel obstruction in pregnancy include adhesions, volvulus, intestinal intussusception, hernia and appendicitis. Volvulus of the sigmoid colon is the most common cause of bowel obstruction complicating pregnancy, accounting for

up to 44 per cent of cases [2]. Another study has shown that in about 25% of cases, volvulus usually affects the large intestine [3]. In our case, there was a history of caesarean section and the obstruction was secondary to a volvulus.

Volvulus of the sigmoid is very rare in non-pregnant women of childbearing age; it most commonly occurs in pregnant women in the third trimester. Harar et al hypothesised that this may be due to the increasing size of the uterus

raising a mobile sigmoid colon from the pelvis and producing a partial obstruction, either due to pressure or bowel kinking [4].

The diagnosis of bowel obstruction in pregnancy is often delayed because the symptoms mimic other complications of pregnancy.

Classic signs of bowel obstruction such as vomiting, abdominal distension and constipation may be absent.

Imaging can help in the differential diagnosis. The unprepared abdominal radiograph shows typical aspects of obstruction in 91% of cases. The usual dose of 0.001 Gy per examination, even repeated for follow-up of patients with suspected bowel obstruction, carries a negligible risk to the fetus in the third trimester [5].

The treatment of bowel obstruction in pregnant women is similar to that of non-pregnant women. Surgery is the mainstay of treatment and should be performed through a vertical midline incision. In the third trimester, if bowel exposure cannot be achieved, a

Caesarean section should be performed. The entire bowel should be examined, viability must be carefully assessed and segmental resection with or without anastomosis is often necessary [6].

When bowel obstruction complicates pregnancy, the prognosis for both mother and fetus becomes guarded. In a series of 66 pregnant women with intestinal obstruction, 23% who intestinal resection with a fetal mortality rate of 26% and four

maternal deaths [6]. In a brief communication by Sascha Dua, a parturient presented 3 days after delivery with a sigmoid volvulus similar to our case. The sigmoid volvulus is likely to have been precipitated by colonic mobility associated with distortion of the sigmoid colon, and also by rapid involution of the uterus [7].

Diagnosing the cause of an acute abdomen is difficult in the immediate postpartum period. Increased abdominal volume and difficulty in obtaining abdominal signs (due to loss of abdominal wall tone) may mask the signs of peritonitis.

CONCLUSION

Digestive obstruction rarely complicates a pregnancy; however, it systematically engages the vital prognosis of the mother and the child. Delayed treatment and diagnosis are the main factors in maternal and fetal morbidity and mortality. The management must be

multidisciplinary by a radiologist, an obstetrician, a resuscitator and a surgeon.

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