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A rare case of sigmoid volvulus with perforation in a young adult with no predisposing factors

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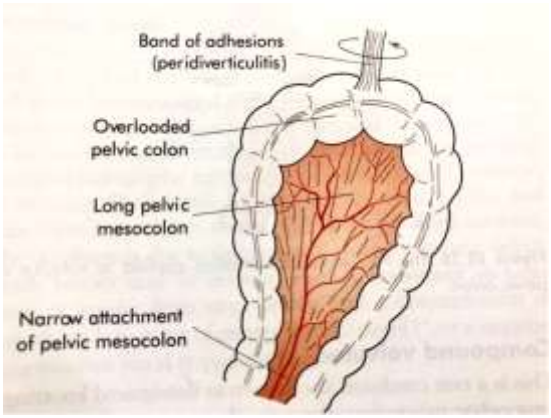
ABSTRACT:
In Sigmoid Volvulus (SV), the sigmoid colon Wraps around itself and mesentry. SV accounts for 2% to 50% of all colonic obstruction and has an interesting geographic dispersion. SV generally affects adults, and it is more common in males.The etiology of SV is multifactorial and controversial; the main symptoms are abdominal pain, distention, and constipation, while the main signs are abdominal distention and tenderness. Routine laboratory findings are not pathognomic: Plain abdominal X-ray radiographs Show a dilated sigmoid colon and multiple small or large intestinal air fluid levels, and abdominal CT and MRI demonstrate a whirled sigmoid mesentry. Flexible endoscopy shows a spiral sphincter-like twist of the mucosa. The diagnosis of SV is established by clinical, radiological,endoscopic, and sometimes operative findings. Although flexible endoscopic detorsion is advocated as the primary treatment choice, emergency surgery is required for patients who present with peritonitis, bowel gangrene,or perforation or for patients whose non-operative treatment is unsuccessful. Although emergency surgery includes various non-definitive or definitive procedures, resection with primary anastomosis is the most commonly recommended procedure. After a successful non-operative detorsion, elective sigmoid resection and anastomosis is recommended.
The overall mortalityis 10% to 50%, while the overall morbidity is 6% to 24%.

KEYWORDS: Intestinal Obstruction, Sigmoid Colon, Sigmoid Volvulus(SV).

I. INTRODUCTION

Sigmoid volvulus is a disease originating from rotation of the colon around its own mesentery. It is classically known as the disease of 7th and 8th decade. It is seen extremely rarely in kids and young adults. The majority of patientswith sigmoid volvulus present with insidious onset of slowly progressive nausea, abdominal pain, distension, and vomiting. 7% of intestinal obstruction.



PREDISPOSING FACTORS

II. PRESENTATION

A young adult male , age 35 years , presented to emergency with complaints of pain in abdomen since 2 days with no passage of stool and flatus for the past 36 hours . The patient complaint of multiple episodes of vomiting withpersistent nausea.

On examination ,
General condition : Poor
Severely dehydrated
Pulse – 110/min. BP- 130/90MM HG
PER ABDOMEN : The abdomen was distended with tenderness in all quadrants and guarding present over lower quadrants. Guarding and rigidity present.
On auscultation , bowel sounds were hypoactive.
Per rectum examination : empty rectum
Wbc count -14*10 cells/cubic mm
Hb -13.5 gm/dl

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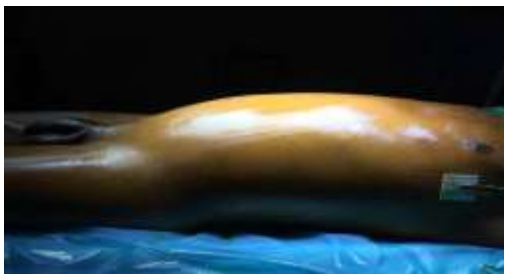
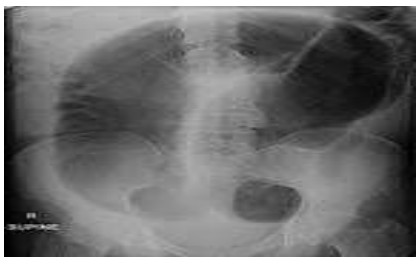
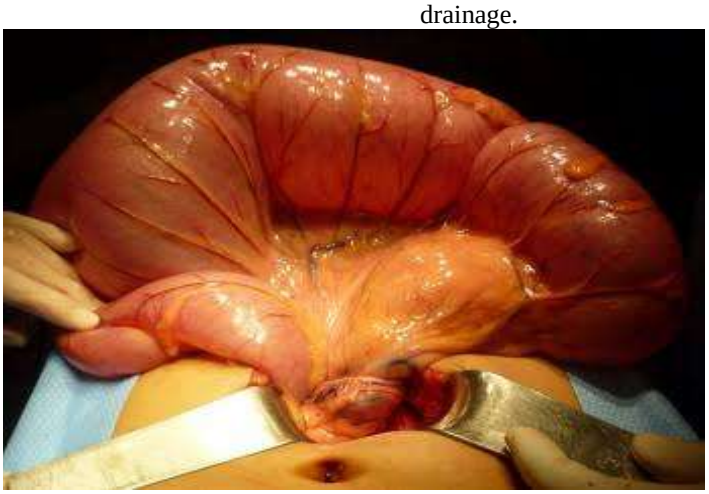


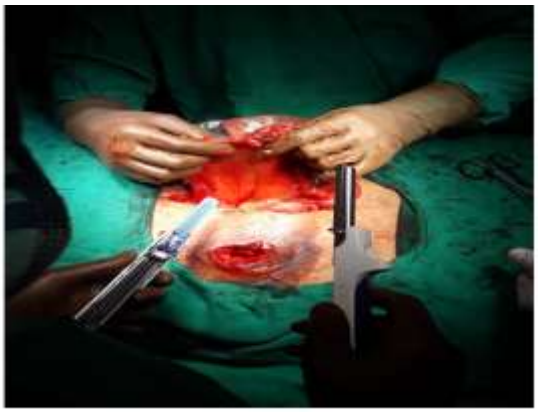


On radiologic examination-X ray – coffee bean appearance (classical sign of sigmoid volvulus)

III. METHOD

The patient was taken for exploratory laparotomy as soon as possible after due pathological and radiological investigations where it was found that sigmoid colon has rotated 1.5 times around its axis along with perforation along the antimesenteric border. The perforation was repaired and sigmoidopexy was done along with ileostomy . The abdomen was closed with drainage.





IV. RESULT

The patient was discharged on post op day 7 with a prescription of oral antibiotics , antacids and probiotics with an advice of follow up after 4 weeks of stoma closure .
Ileostomy closure was done after 2 months .

V. CONCLUSION

The most important step in a young patient towards diagnosis of sigmoid volvulus , is to consider the diagnosis , it should be kept in mind that sigmoid volvulus could develop with young patients and investigations should be continued until the diagnosis of sigmoid volvulus is excluded in a patient with signs of bowel obstruction.