A Case Series on Congenital Gastrointestinal Anomalies with Acute Abdomen in Adults

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Abstract
Congenital anomalies of gastrointestinal tract are a significant cause of morbidity in children and less frequently in adults. In rare cases, they may run undetected during childhood and may present during adolescents. These abnormalities include developmental obstructive defects of the duodenum and the small intestine, anomalies of rotation and fixation, intestinal duplications and anomalies of the colon & rectum. Sometimes, GI anomalies presents with acute abdomen like intestinal obstruction, strangulation, perforation which increases the morbidity &mortality.

Keywords: Gastrointestinal anomalies, intestinal obstruction

Introduction
Case 1
16 year old male came with % abdominal pain, vomiting for 4 days. He had past h/o herniotomy done for right congenital inguinal hernia at the age of 2 months and h/o herniorrhaphy done for right recurrent inguinal hernia. On admission, patient conscious, oriented. Blood pressure was 100/70mmhg, Pulse rate was 98/min. Covid swab positive with 5% lung involvement. P/A Distended abdomen, diffuse tenderness present more on RIF, guarding present in RIF. No fecal staining on Digital rectal examination.

X ray abdomen showed multiple air fluid levels

CECT abdomen report came as acute small bowel obstruction with distal small bowel volvulus.

Pt was proceeded with emergency laparotomy. Intraoperative findings were patent VITELLOINTESTINAL DUCT causing distal ileal obstruction. Resection of patent vitellointestinal duct and primary closure of ileal defect was done.
Case 2:

48 year old male came with % abdominal pain for 2 months on and off, vomiting for 1 month, vomits out after taking food. He had no comorbidities. On examination, pt conscious, oriented. VITALS were stable. Per abdomen examination showed epigastric fullness with tenderness, no guarding/rigidity. Normal fecal staining present in digital rectal examination.

CECT abdomen report came as Complete annular pancreas with D1 and stomach distension.

Pt was preceded with laparotomy. Intraoperative findings were dilated stomach and first part of duodenum, pancreas appeared to be completely encircle the second part of duodenum.

Then, pt was proceeded with Truncalvagotomy and posterior GASTROJEJUNOSTOMY.

Oral intake started on post operative day 6. Pt was discharged on postoperative day 9.
Case 3:

40 year old male came with % abdominal pain, postprandial pain for one month. He had h/o abdominal distension after food intake, h/o vomiting for 2 weeks. He had no h/o constipation or obstipation. On examination, pt conscious, oriented. Blood pressure was 110/70mmhg, Pulse rate was 98/min. P/A Distension with epigastric tenderness was present, no guarding/rigidity. Normal fecal staining present in digital rectal examination. CECT abdomen report came as highly tortous SMA course with fusiform aneurysm of right branch of SMA and twisting of mesentery along the SMA course. CT angiogram revealed as intestinal malrotation with midget volvulus, Duodenojejunal junction located on right side of the spine at L2 vertebral body, jejunal and ileal loops predominantly located on right side of the abdomen, ileocaecal junction located at right lumbar region, SMA and SMV were normal in its axis. Pt was taken up for laparotomy.

Intraoperative findings:

1. Ladds band was present
2. adhesion between distal ileum and root of mesentery causing midgut volvulus,
3. DJ flexure was seen in the right side,
4. leocaecal junction was in the right subhepatic region.

Midgut volvulus was derotated.

Pt was proceeded with Ladds procedure. It includes division of ladds band, straightening of DJ flexure, widening of root of mesentery, Appendicectomy, Functional positioning of the intestine (Small bowel on right side, large bowel is on left side)

Postoperatively oral intake started on POD 2, pt was discharged on POD 7
Adhesion released b/w distal ileum & root of mesentery

Ladd's band

Midgut volvulus

2. Straightening of DJ flexure

Widening of Root of mesentery

Appendicectomy
Case 4

18 year old male came with % abdominal pain, vomiting for 3 days. He had h/o not passed stools and flatus for 2 days. H/O malrotation of gut with one episode of subacute Intestinal obstruction being treated conservatively one year back.

On examination, pt conscious, oriented. Pulse rate was 112/min, blood pressure was 90/60mmhg.

Per abdomen: Diffuse tenderness and guarding present more on the right hypochondrium. No fecal staining present in digital rectal examination.

CT ABDOMEN was reported as malrotation of gut with SMV anterior to the SMA and dilated small bowel loops of 3.8cm.

Pt was taken up for emergency laparotomy

**Intraoperative findings:**

1. About 1.5 litre of hemorrhagic peritoneal fluid present
2. Gangrene of ileum 150cm from the DJ flexure until 5cm from the Ileocaecal junction
3. Band arising from the lateral pelvic wall to the ascending colon, below which mesentery was twisted
4. DJ flexure on the right side, meckels diverticulum was there.

Proceeded with resection of gangrenous bowel and band release with double barrel ileostomy at right iliac fossa.