The Journal of
OBSTETRICS
AND
GYNECOLOGY
of India

J Obstet Gynecol India Vol. 59, No. 5: September/ October 2009 pg 460-461

Case Report

Peripartum Intestinal Obstruction

Guruvare Shyamala [1], Kushtagi Pralhad [2], Rao Anand BH [2]

[1] Associate Professor, [2] Professor

Department of Obstetrics and Gynecology and Surgery, K asturba Medical College, Manipal- 576104

Key words: intestinal obstruction, pregnancy, postpartum

Introduction

Surgical complications are rarely suspected in pregnancy. Delay in the diagnosis of intestinal obstruction may contribute significantly to maternal mortality, around 20%[1,3]. One such case that posed a clinical dilemma is reported.

Case report

A 32-year old nulliparous second gravida aged 32 years with gestational diabetes and mobile fetal head was admitted at term on 13th November 2004. The night before scheduled cesarean, she had an episode of excessive sweating along with maternal bradycardia and spontaneous fetal heart decelerations. The episode was managed as hypoglycemia. As scheduled, cesarean section was done on 15th November, 2004 and a female baby weighing 3.2 kg was delivered with apgar of 9 at 1 minute and 10 at 5 minutes.

Paper received on 15/10/2006; accepted on 05/12/2006

Correspondence:
Dr Guruvare Shyamala
Department of Obstetrics and Gynecology
Kasturba Medical College, Manipal 576104
Tel. 0820 2922211
Email : shyamala_doc@yahoo.co.in

The patient complained of generalized intense pain abdomen 8 hours after cesarean and was managed with analgesics. The pain persisted and by eighteen hours post operation abdominal distension was noticeable and bowel sounds were absent. A palpable tender mass was noted in right hypochondrium. X ray and ultrasonography abdomen showed grossly distended small bowel loops with air fluid levels (Fig1). Conservative management for intestinal obstruction failed to improve the condition. Exploratory laparotomy on the 4th postoperative day i.e. 18th November, 2004 revealed gangrenous terminal ileum and the adhesive band that caused the obstruction (Fig 2). Release of fibrous band with resection of gangrenous ileal segment and end-to- end anastomosis was done.

The patient made gradual recovery following complicated postoperative period requiring intensive multidisciplinary care with ventilator support.

On enquiry it was found that the atient had an appendicectomy two years earlier, following which she had abdominal pain on and off.

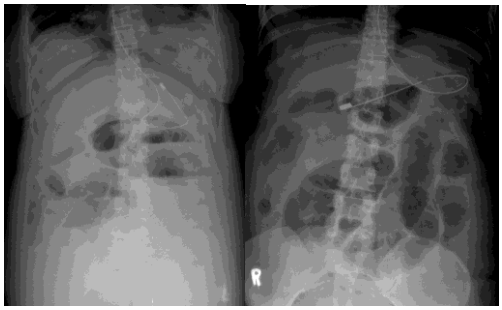

Fig 1. A). Supine radiograph showing multiple dilated small bowel loops
B). Erect abdominal radiograph showing multiple air- fluid levels in dilated small bowel loops.

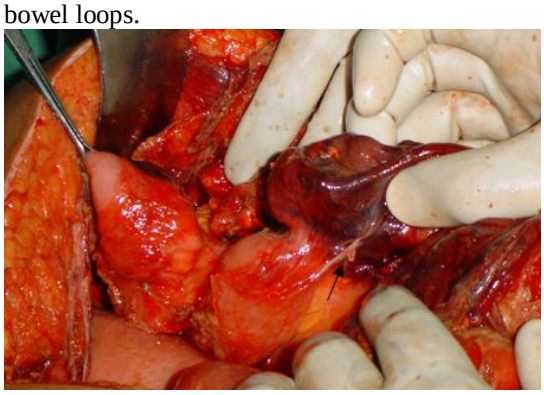

Fig 2.Photograph showing adhesive band and the gangrenous ileal loop.

Discussion

Adhesions due to past surgery, e.g appendicectomy are the commonest cause for intestinal obstruction in pregnancy. Transition from first to second trimester when uterus and adnexa become abdominal, entering of the head in the pelvis near term and soon after delivery are periods when obstruction can manifest[2,3]. The patient reported here had an appendicectomy two years earlier. She had evidence of intestinal disturbances after appendicectomy in the form of on and off pain abdomen, diarrhea followed by constipation that she had near term and the episode of sweating with transient bradycardia the day before cesarean delivery. The window formed by the fibrous band of adhesion letting in loops of intestine may have been the cause of on and off pain in abdomen as well as the cause of the bowel disturbances she had near term. Probably the episode of sweating with transient bradycardia could have been due to a significant obstruction. The bowel distension due to post cesarean ileus would have caused strangulation of the obstructed loop of the intestine.

The pain she experienced was thought to be postoperative pain. Abdominal distension with a palpable mass and dilated bowel loops on x-ray was attributed to postoperative ileus. It was her deteriorating clinical condition that led to laparotomy being performed.

Intestinal obstruction should be thought of whenever a pregnant woman with past abdominal surgery presents with bowel disturbances and abdominal distension. Prompt diagnosis and active intervention will minimize the morbidity.

References:

1. Perdue PW, Johnson HW, Stafford PW. Intestinal Obstruction Complicating Pregnancy. Am J Surg 1992; 164: 384-8
2. Connolly MM, Unti JA, Nora PF. Bowel Obstruction in pregnancy. Surg Clin North Am 1995; 75: 101-13
3. Yahchouchy E, Zaarour P, Prove S, et al. Recurrent idiopathic small bowel volvulus during pregnancy. ANZ J Surg 2001; 71: 194-6