INTESTINAL OBSTRUCTION SIMULATING HYPEREMESIS GRAVIDERUM

(A Case Report)

by

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Introduction

Nausea with occasional vomiting in the morning is a common ailment of normal pregnancy in the first trimester and may extend to second trimester in a few cases. Pernicious vomiting of pregnancy is rarely found now-a-days and termination is not usually indicated due to its response to early treatment. But some extragestational causes of vomiting along with pregnancy mimic this clinical condition 'Hyperemesis Gradiverum' in such a way that correct diagnosis and treatment become most difficult. Here a very interesting case report of tubercular lesion in upper abdomen leading to obstruction of gastrointestinal tract is being reported whose diagnosis was misleading till the microscopical report of the biopsy material from the laparotomy, done after a few days of the termination of pregnancy, was available.

CASE REPORT

Mrs. S. V., 24 years, P_0 + 0 carrying 6½ months was admitted in S.S.K.M. Hospital on 13-5-75 because of excessive vomiting for 1½ months, extreme weakness associated with muscle cramps for 1 month, scanty urine and constipated bowel with excessive thirst for 1 month. The patient started vomiting once or twice a day from 12 weeks of pregnancy, which was excessive from the 20th week of pregnancy. She would vomit even with liquid diet. Clinical jaundice appeared within 15 days. She was admitted twice before in a nursing home, and she was treated conservatively with slight improvement each time. For the last fifteen days she had developed severe and persistent vomiting, which was profuse and projectile with a vague epigastric discomfort and a sense of something moving from left to right in upper abdomen. She had past history of cervical ymphadenopathy 5 years back, and was treated conservately. Appendicectomy by Mcburney's incision was done 1½ years back.

On examination during admission—her general condition was low, facies was anxious and apprehensive with shrunken eye balls. Moderate dehydration was present with dry tongue. Pulse was 120/min and respiration 24/min., B.P. 85/56 mm. of Hg.

Her abdomen was soft on palpation. A hypogastric bulging with lower abdominal swelling was present. Oblique scar about 3" at Mcburney's point was present. Visible peristalsis from left to right was occasionally seen Duodenal point was slightly tender.

Peristaltic sound was slightly exagerated. Uterus could be palpated as 26 weeks of pregnancy and F.H.S. was regularly heard. Tetanic muscle was found with positive Trocissoni sign. Jerks were equally diminished on both sides and planter reflex was flexor.

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Laboratory Investigations — Blood — Hb —9 gm%. E.S.R.—108 mm (mean): Icteric index—12.0 unit. S.G.O.T.—90 I.U., Serum alkaline phosphatase—11.2 K.A. Serum Na—128 mEq/litre, Serum K—3.5 mEq/litre. Serum Chloride —91 mEq/litre. Urea—31 mgm/100ml. Sugar—90 mgm/100 ml. **Urine:** Sp. gr. 1018, acid in reaction, bile—present a trace, Ca-oxalate and urate crystals were present.

Straight X-Ray of the abdomen showed 'no evidence of intestinal obstruction. There was no dilatation of stomach suggestive of pyloric stenosis'.

Provisional diagnosis

(1) Hyperemesis graviderum (with hypochloremic alkalosis and Tetany). (2) Pyloric obstruction (with metabolic alkalosis and Tetany).

Treatment

Conservative treatment was started with intravenous infusion nasogastric suction, injection stemetil/siquil, injection Calmpose, injection Vitamin B Complex and injection Vitamin B_6. Patient improved a little, dehydration was corrected. B.P. improved (100/80 mm. of Hg.). Urinary output increased from 60—100 c.c. per day to 800—900 c.c. per day. But the vomiting persisted.

As no marked improvement could be achieved with conservative treatment, termination of pregnancy was decided upon at 31 weeks of gestation with Ethacridinelactate 100 cc extra-ovular along with unitocin (1 cc I.M. 4 hourly x 4 such). Assisted breech delivery of a living female baby (1.500 Kg.) was done.

Vomiting persisted even after the termination of pregnancy. Five days after the childbirth a mobile mass of the size of hen's egg was occasionally palpable under the examining finger in right hypochondrium. On the 11th puerperal day, the patient suddenly vomited coffee-ground vomitus demanding blood transfusion. Due to steady deterioration of the condition, exploratory laparotomy was done on the 14th puerperal day and a mass (5 cm. x 5 cm.) behind the pylorus and 1st part of duodenum with inflammatory oedema and adhesions with surrounding structures was found. Left gastroepiploic vein was grossly dilated. Subpyloric lymph nodes were enlarged and fleshy in appearance. Upper jejunum, 8 cm. below the flexure, shwed an obviously malignant deposit (2 cm. x 2 cm.) on its wall. Liver was free. Posterior short loop gastro-jejunostomy with biopsy from subpyloric nodes was done. Microscopical report of biopsy from sub-pyloric gland showed "Caseous tubercular lesion of the lymph node". Patient recovered to normal health with antitubercular regime and the baby was doing well.

Discussion

Vomiting due to lesions in gastro-intestinal tract is very difficult to diagnose during pregnancy. One problem is that the symptoms and signs of gastro-intestinal tract obstruction may be confused with that of normal pregnancy and another is that the gravid uterus stands in the way of proper examination of the organic lesions.

The incidence of intestinal obstruction in pregnancy which might be the cause of severe vomiting in pregnancy is occasionally found in literature. Bellingham *et al* (1949) reported 10 cases of intestinal obstruction in pregnancy of which 9 cases had history of previous abdominal surgery. Waters and Fenimore (1950) also reported fatal intestinal obstruction during pregnancy where mortality was very high. Baker and Barnes (1953), Svesko and Pisani (1960), Harer and Harer (1958, 1962), Morris (1965), Browne and Dixon (1970) all had emphasized on the delayed diagnosis of intestinal obstruction for vomiting in pregnancy and its fatal outcome. Weston and Lindheimes (1971) reported a case of "Intermittent intestinal obstruction simulating hyperemesis graviderum" where also high jejunal obstruction due to adhesion, malrotation of small gut and a mobile coeceem was found to be the cause. Beck (1974) with 2 case reports, pointed out that surgical scar on abdomen of pregnant woman with complaints of pain, vomiting, constipation and cramps should hint at this diagnosis.

Bhatta (1965) reported 2 cases in Indian literature. Das *et al* (1968) reported 7 cases and showed that tubercular lesion of abdomen to be the responsible factor in 4. Recently Magar *et al* (1976) also reported 2 cases of intestinal obstruction in pregnancy. In the present case, abdominal scar of appendicectomy contributed nothing, whereas the past history of cervical lymphodenopathy might be the correlated exciting factor for tubercular lesion in upper abdomen. Tuberculous lesion of upper gastro-intestinal tract as in pylorus or jejunum is usually very rare and evacuation of the uterus followed by laparotomy has only helped us for its diagnosis. Hence the obstetrician should not be too conservative in conditions like hyperemetic state in pregnancy as termination of pregnancy may help not only to treat her hyperemesis but to elicit other organic lesions after evacuation of uterus.

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