INTESTINAL VOLVULUS DURING PREGNANCY
(A Caset Report)

by

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Volvulus refers to a twist of a viscus on its mesentry of such a degree as to occlude its blood supply partially or completely. It occurs most commonly in the pelvic colon being less common in the small intestine. Devlin has reported several cases of midgut rotation causing volvulus in the adult patients. Bailey and Love observed volvulus involving many feet of small intestine without causative adhesion occur rather commonly amongst Africans and vegetables predispose to the condition. Whether the pregnancy state by altering the anatomical arrangement of the bowel plays any role in the aetiology is yet to be proved.

CASE REPORT

Mrs. S. a 22 year-old primigravida was admitted on 19th February, 1980 for 8 months' ammenorrhea, pain in the abdomen and vomiting since several days. She had been admitted with similar complaints in January 1980 when she had been diagnosed as having "false pains" and after forty-eight hours of observation she was discharged.

Her past menstrual cycles were regular. Her last menstrual cycle was 1st June 1979 and so her calculated expected due date of delivery was 8th March 1980.

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There was no history of any significant illness in the past.

General Examination of the patient revealed the following findings:

Pulse 120 beats per min. regular, blood pressure 124/80 mm. of Hg. She had moderate pallor, there was no oedema of the feet. No significant abnormal findings were detected in the cardiovascular or respiratory system.

Abdominal Examination revealed that there was epigastric fullness. Uterus was of 32 weeks gestational size. Fetal position and presentation were difficult to recognize as there was marked tenderness and guarding and all over the abdomen. Fetal heart sound were absent. Peristalsis were normal.

Vaginal examination revealed that the cervix was two centimetres dilated, fifty per cent effaced; membranes had ruptured and the liquor amnii was clear.

She was diagnosed as a case of acute abdomen and immediate laparotomy was decided.

On investigations her Hemoglobin was 9.5 gms. per cent. Blood group AB Rh positive, Blood V.D.R.L. negative. Serum electrolytes were within normal limits. Plain X-ray of the abdomen showed few gaseous filled small intestines.

A laparotomy under general anaesthesia was undertaken. On opening the abdomen the uterus was 32 weeks and relaxed, there was no petechial haemorrhage on the uterine surface. The jejunum, ileum caecum, ascending colon and transverse colon showed gangrenous changes due to malrotation. A lower segment caesarean section was done to deliver a dead male fetus weighing 1.6 kilograms. This was followed by resection of the gangrenous bowel followed by anastomosis of the duodenum to the transverse colon.

Her post operative period was uneventful.

She was given I.V. gentamycin 80 mgm. B.I.D. and hyperalimentation. A barium enema to study the status of the bowels was done two weeks after laparotomy (Fig. 1).

Discussion

Surgical complications are rare features during pregnancy. Early diagnosis and prompt management is essential for reducing maternal mortality. Volvulus of the bowel is extremely rare and invariably fatal unless treated immediately.

Conclusions

Case history of intestinal gangrene following volvulus during pregnancy has been presented.

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See Fig. on Art Paper XII