

orchidopexy offers only limited protection against future malignancy if performed after two years of age, most are known to be infertile and the difficulty in separating the gonads and the vas without damage<sup>7</sup>.

If this is necessary on both sides, there is the additional problem of lifelong testosterone substitution which requires efficient patient monitoring and good patient compliance. In cases where this cannot be achieved, compromises, such as temporarily delayed orchidectomy, may be considered.

The surgical management PMDS is still controversial. Due to the risk of malignancy, contrary to previous suggestions<sup>3,4</sup>, it is now recommended to remove the persistent mullerian derivatives<sup>7</sup>.

The patient or his family should be completely informed of the diagnosis, the surgical options and the need for long-term follow-up as the possibility of infertility and malignant transformation is rather high<sup>3</sup>. Finally, genetic counseling must be offered to the patient or his parents because of the possible chromosomal origin of the syndrome.

PMDS is usually discovered accidentally during surgical exploration for undescended testis and inguinal hernia repair. Therefore a staged procedure is the most viable option. First procedure includes testicular biopsies, replacement of the testis, uterus and Fallopian tubes in the pelvis and Hernioraphy. After PMDS has been confirmed by investigation definitive surgery can be performed. The vasa deferentia are usually found to be adherent to the lateral walls of the uterus on the removal of Mullerian remnants will damage both the vas deferens

and the blood supply of the testis.

There are no reports of malignancy arising from Mullerian remnants, for these reasons the removal of these structures is no longer recommended. The surgical approach by Guerrier et al bilateral proximal salpingectomies, leaving fimbriae attached to epididymis, corporal hysterectomy and bilateral orchidopexy has been preferred by some teams

## CONCLUSION

Surgeons who frequently repair inguinal hernias should be aware of the appropriate surgical management options available to them when this condition is unexpectedly identified during inguinal exploration.

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## Case Report

# Hamartomatous Duodenal Polyp leading to Duodeno- Jejunum Intussusception – A Rare Case Report.

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**Abstract:** Intussusception is the invagination of one segment of intestine into another, first described by Barbet of Amsterdam in 1674. Most common variety of intussusception is generally ileo-colic type. We present a case of 30 year old adult male having hamartomatous duodenal polyp leading to duodeno-jejunal intussusception.

## CASE REPORT

A 30 year old adult male presented with chief complaints of vomiting and malena for 2 days. There was history of intermittent abdominal distention since 2 months. General physical and per rectal examination was normal. Abdominal examination revealed no palpable mass, abdomen was soft and there was no tenderness or guarding but on percussion liver dullness was obliterated. Erect chest X-ray showed free air under diaphragm. Nasogastric aspiration revealed large amount of bilious fluid. In view of prolonged abdominal distention, high nasogastric aspiration and free air under right dome of diaphragm, patient was taken up for exploratory laparotomy. Exploratory laparotomy revealed a grossly dilated duodenum with multiple diverticuli, multiple polyps in duodenum and jejunum with duodeno-jejunal intussusception (Fig. 1 and 2). Rests of bowel findings were normal.

Patient underwent resection of diseased jejunal segment right up to the DJ

flexure and duodenal jejunal end to side anastomosis. The biopsy of duodenal and jejunal polyp showed Hamartomatous polyp. Postoperative period was uneventful for patient and patient was discharged in satisfactory condition with regular follow up.



Fig. 1: Grossly dilated duodenum with intussusception



Fig. 2: Multiple large polyp

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## DISCUSSION

Intussusception is common in children and rare in adults. About 90% of intussusception in adults is caused by definite underlying disorder such as neoplasm or by a postoperative condition. However a specific lead point is identified in more than 90% of cases<sup>2</sup>. Most intussusception in adults are associated with either acute intestinal obstruction or partial and recurring obstruction. A correct and timely diagnosis is not only necessary to avoid the complications of bowel infarction and perforation secondary to high grade obstruction but also to resect the underlying lesion that serve as a lead point<sup>3</sup>. Polyps causing small bowel intussusception are uncommon but not rare<sup>4</sup>. Hamartomas are tumors with abnormal development of tissue. Hamartomatous polyps causing intussusception in gastrointestinal tract often occurs in association with Peutz-Jegher Syndrome (P-J Syndrome). Infact Hamartomatous polyps are found in nearly all

patients of P-J Syndrome<sup>5</sup>. The patient in our case report does not fit in the criteria of P-J Syndrome. Patient had multiple polyps of duodenum and jejunum which were the lead points for small bowel obstruction and these polyps were proven to be Hamartomas on histopathological examination. The patient in our case report underwent resection of jejunal segment along with the polyps and duodeno- jejunal anastomosis. Patient postoperative period was uneventful and is now planned for close monitoring with endoscopy.

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## Case Report

### Meckel's Diverticulum Presenting as Intestinal Obstruction due to Faecal Impaction – A Rare Case Report.

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**Abstract:** Meckel's diverticulum represents a true diverticulum of the ileum containing all three layers of the bowel wall and is found on the wall of the distal ileum, usually about 2 feet from the ileocaecal valve. Although Meckel's diverticulum is a common congenital abnormality of the gastrointestinal tract, it is often difficult to diagnose. We report an unusual case of intestinal obstruction due to impaction of faecal matter within the Meckel's diverticulum and the adjacent part of ileum forming a firm mass like structure. The obstruction was not due to enterolith as has earlier been reported in a few cases.

## INTRODUCTION

Meckel's diverticulum represents a true diverticulum of the ileum containing all the three layers of the bowel wall and is found on the wall of the distal ileum, usually about 2 feet from the ileocaecal valve. Although Meckel's diverticulum is a common congenital abnormality of the gastrointestinal tract, it is often difficult to diagnose. Meckel's diverticulum generally presents in children with bleeding, diverticulitis or intestinal obstruction. Intestinal obstruction occurs in about 30% - 56% of symptomatic cases<sup>1,2,3</sup>. The signs and symptoms of intestinal obstruction may result from a volvulus<sup>1,3</sup>, adhesion and kinking<sup>2</sup>, internal herniation<sup>3</sup>, Littre's hernia<sup>2</sup>, intussusception<sup>1,2,3</sup>, or inspissations or impaction of the diverticulum with milk curd<sup>4</sup>, we present an unusual case of intestinal obstruction due to impaction of faecal matter within the Meckel's diverticulum and the adjacent part of ileum in a 42 year old male.

## CASE REPORT

A 42 year presented at the surgical emergency with complaints of abdominal distension and non passage of stools since 6 days. On admission pulse 110 / min, BP 112/72 mm Hg, body temperature 101° Fahrenheit, there was history of off and on vomiting episodes. Patient had not taken orally since the problem started. On examination the abdomen was distended. Per rectal examination



**Fig. 1:** Meckel's diverticulum where faecal matter was impacted seen after milking of the faecal matter.

was negative. Patient was adequately hydrated. Antipyretics were given. An abdominal X-ray in the erect posture was done which showed multiple air-fluid levels. A diagnosis of intestinal obstruction was made. Since already 6 days had elapsed and the obstruction had not relieved, it was decided to operate upon the patient. At surgery it was found that a small Meckel's diverticulum was present (fig.1) approximately 2 ft from the ileo-caecal valve proximally. It was impacted with faecal matter forming a mass like structure. The faecal matter was also filling the adjacent ileal loop. The gut loops distal to the impaction were not dilated. The mass prevented the passage of any intestinal contents beyond it. On careful manipulation, it was possible to disrupt the faecal matter by applying firm pressure. It was then milked into the large gut. Subsequently diverticulum was carefully examined. Its wall was not thickened and there was no in duration at the base or of the adjacent intestinal wall: A diverticulectomy was performed and the defect was repaired. Post operatively patient's recovery was uneventful.

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