

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 cases². 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 point³. Polyps causing small bowel intussusception are uncommon but not rare⁴. 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 Syndrome⁵. 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.

REFERENCES

1. Barbette P. *Ouevreschirurgiques at anatomiques*. Geneva: Francois meige ; 1674
2. Agha FP. Intussusception in Adults. *AJR* 1986; 146: 527-531
3. Seung Hong Choi, Joonkoo Han, Se Hyung Kim, Jeong Min Lee, Kyong Ho Lee, Young Jun Kim, Su Kyung An and ByungHm Choi. Intussusception in Adults from stomach to rectum. *AJR* 2004; 183: 691-698
4. Thapa M.M, Pruthi S, Ishak GE, Otto R. Reduction of small bowel intussusception caused by jejunalhamartomatous polyp documented by interoperative video. *Radiology case Reports (online)* 2009; 4: 292
5. Choi HS, Park YJ, Park JG. Peutz- Jegher Syndrome: a new understanding. *J Korean Med Sci* 1999 Feb; 14(1): 2-

Case Report

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

Saurabh Jindal, Sartaj Sandhu

Department of Surgery, Rajindra Hospital/Government Medical College, Patiala, Punjab India

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^{1,2,3}. The signs and symptoms of intestinal obstruction may result from a volvulus^{1,3}, adhesion and kinking², internal herniation³, Littre's hernia², intussusception^{1,2,3}, or inspissations or impaction of the diverticulum with milk curd⁴, 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.

Correspondence: Dr. Saurabh Jindal, Jindal Hospital, Kachehry Bazar, Rampura Phul, Dist Bathinda-151103, Punjab, India
e-mail: dr.saurabh07@gmail.com

DISCUSSION

Meckel's diverticulum was originally described by Fabrius Hildanus in 1598. However, it is named after Johann Friedrich Meckel, who established its embryonic origin in 1809. The most common presentations of Meckel's diverticulum are gastrointestinal bleeding from associated ectopic gastric mucosa, diverticulitis, perforation and neoplasia, uncommon presentations include axial volvulus of the diverticulum and internal herniation⁵. Small bowel obstruction can be the result of intussusceptions, strangulation due to a mesodiverticular band or volvulus. Few cases of intestinal obstruction due to enterolith have been reported⁶. It was postulated that calcium from the intestinal contents gets precipitated which initiates the formation of stone. But in our case there was no stone or whatsoever. The faecal matter first got trapped in the pouch of diverticulum and then progressed to involve the adjacent loop of ileum. It formed a firm to hard mass which prevented to crush the mass into small pieces which were then milked into the large intestine. The cause of faecal impaction couldn't be elucidated. May be the narrow mouth of the diverticulum initiated the process of faecal impaction and then followed to involve the adjacent ileal loop resulting in formation of a hard mass causing obstruction. After emptying, diverticulectomy was done as it was

narrow mouthed. The adjacent ileum was normal and there was no induration of the adjacent ileal mucosa. So the adjacent ileal loop was not resected. Therefore, diverticulectomy only with sparing of the adjacent ileal loop is justified in our case.

CONCLUSION

Meckel's diverticulum is itself a rare entity and most commonly it presents as gastrointestinal bleeding. Obstruction if at all is due to adhesions and kinks or volvulus but that occurring due to faecal impaction is very rare and should be treated as any other intestinal obstruction.

REFERENCES

1. Meguid M, Canty T, Eraklis AJ (1974) Complications of Meckel's diverticulum in infants. *Surg Gynecol Obstet* 139: 541-544.
2. Michas CA, Cohen SE, Wolfman EF Jr (1975) Meckel's diverticulum: should it be excised incidentally at Operation? *Am J Surg* 129: 682-685.
3. Si-Vil D, Brandt MI, Panic S, Bensoussan AL, et al. (1991) Meckel's diverticulum in children: a 20-year review. *J Pediatr Surg* 26: 1289-1292
4. Da la Hunt MN, Rangescroft L (1993) Intraluminal milk curd obstruction in a giant Meckel's diverticulum. *J Pediatr Surg* 28: 955-956.
5. Moore CP, Burkle FM Jr. Isolated axial volvulus of a Meckel's diverticulum *Am J Emergency Medicine* 1988; 6: 137-142.
6. Hui-Chein Lai. Intestinal obstruction due to Meckel's enterolith. *Pediatrics and Neonatology* 2010; 51 (2): 139-140.

Case Report

Gullian- Barre Syndrome associated with Herpes Zoster Virus Infection - A Case Report.

N. S. Neki, Ishu Singh, Tamilmami, Himanshu Gupta

Deptt. of Medicine, Govt. Medical College/Guru Nanak Dev Hospital, Amritsar, Punjab, India.

Abstract: Gullian- Barre Syndrome (GBS) is a rare disease manifesting as severe, generalized, flaccid paralysis & areflexia. GBS resulting from Herpes zoster is a rare & unusual association. The pathogenesis of post zoster demyelinating polyneuropathy & other widespread complications of herpes zoster is poorly understood. We report a case of GBS following a recent herpes zoster attack.

INTRODUCTION

Since the first report in 1961, only few cases of Gullian- Barre Syndrome following herpes zoster have been reported in the literature^{1,2}. GBS usually occurs as a post – infective immune- mediated phenomenon. Many precipitants have been recognised & it is known that Varicella zoster virus (VZV) infection may trigger GBS. However this is rare. VZV is a herpes virus which causes both varicella (chicken pox) and herpes zoster (shingles). It is postulated³ that during the viraemic phase of a primary varicella infection, the virus reaches the skin & travels along the sensory axons to the dorsal root ganglion, where it can remain in a latent phase for years before it is reactivated. A case of GBS following herpes zoster viral infection is being reported here for its rarity.

CASE REPORT

A 42 year old male patient presented with 3 days history of cough, fever & multiple bullous eruptions on the right side of face & trunk. Six

days later, he reported sudden onset sharp lumbar pain which radiated to the right leg accompanied by bilateral lower limb muscle cramps. Four days later, he developed parasthesia, numbness & tingling sensation in both feet followed by weakness of both lower & upper limbs. He was unable to walk & speak properly. There was no history of bladder or bowel impairment, no history of injury, vaccination or exposure to toxins or loss of taste sensation. On examination, he was conscious, oriented, afebrile, BP 120/80 mmHg, pulse 94/min, regular. There was scarring & crusting over the distribution of eruptions on the right side of face & trunk. Bell's palsy was present on the right side. He had more weakness of lower limbs (2/5) as compared to upper limbs (4/5). Deep tendon reflexes were absent & plantars were flexor bilaterally. Sense of vibration, joint position & pinprick was impaired distally in the limbs. All the muscles were not unduly tender. Laboratory investigations revealed Hb 11.2 g/dl; TLC 11300/mm³; DLC P73, L27, E0, B0; ESR 47mm/hour; B.urea 37mg%; S.creatinine 1.2%; urine C/E normal. CT Brain, CSF examination & chest X ray was normal. CT myelography was normal. Serological tests for syphilis & systemic lupus