

Acute abdomen without diagnosis: exploratory laparoscopy as the initial management - a clinical case

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CLINICAL CASE

A 74 years old Caucasian female with no previous relevant disease presented to the emergency department with a 4-day history of constant abdominal pain in the right iliac fossa associated with anorexia and dysregulation of bowel. At physical examination the patient experimented pain in the right iliac fossa associated with guarding and rebound tenderness.

Blood tests revealed mild elevation of C-reactive protein.

Abdominal CT scan (Fig. 1 and 2) revealed "inflammatory densification in the mesentery in the right iliac fossa with an irregular thickening of an intestinal loop (presumably ileum) and associated reactive ganglia. (...) The case was discussed with the radiologist that suspected of a partial occlusion due to internal hernia.

Due to the persistence of the complaints, it was proposed an exploratory laparoscopy to the patient. During the procedure it was diagnosed an inflammatory process in the distal ileum with fibrin and adhesions between ileal loops. The adhesions were lysed laparoscopically with care and throughout this process it was identified a foreign body compatible with a fishbone with 20mm (Fig.3). There was evidence of focal peritonitis, although there were no signs of macroscopic perforation. The procedure was done with minimally invasive techniques (laparoscopy)- 3 incisions with a maximum of 1,5 cm long.

A further history was sought and the patient revealed that had ingested fish a few days before the pain started. The patient was discharged at the 7th day after surgery and was observed in the specialty follow-up appointment without any complaint.

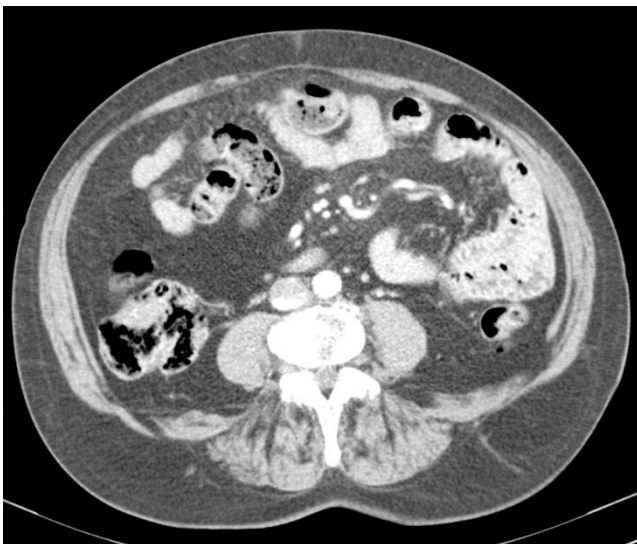


Fig 1. Abdominal CT scan with contrast.



Fig 2. Abdominal CT scan with contrast .

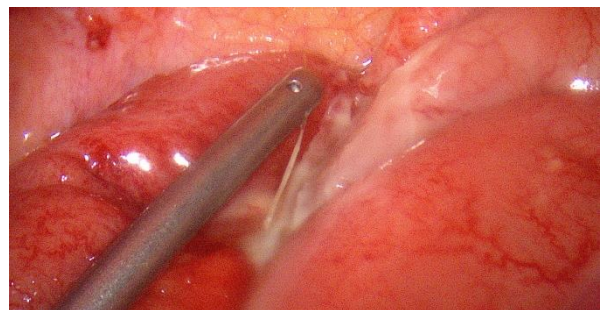


Fig 3. Picture of a fishbone caught in a suction tube during laparoscopy.

DISCUSSION

Although foreign body ingestion is a common event, it rarely causes an acute abdomen. And only around 1% causes perforation. (1) The site of perforation dictates the signs and symptoms associated and the differential diagnosis. The most common symptoms are pain, nausea, vomiting and diarrhea. The foreign bodies are most likely to perforate in angulated or narrowed portions of the gastrointestinal tract. Although it is described the recognition of foreign bodies with the ultrasound and despite the innumerable advantages of this method, CT is the method of choice for identifying ingested foreign bodies and their complications. The main features of a fishbone perforation on a CT scan are focal wall thickening, fat stranding, bowel ileus, ascites, localized pneumoperitoneum, intra-abdominal abscess and a linear hyperdense structure in the GIT or within a parenchymal organ. (2) The treatment of this condition usually involves resection of the bowel or suturing of the defect. In this particular case there was no visible perforation and the ileal loops were viable so the only intervention needed was to lyse the adhesions.

CONCLUSION

The main goal of this poster is to enhance the diagnostic and therapeutic decisions of this case. In fact, as the CT scan didn't reach a diagnosis, the surgical team had to decide a more invasive diagnostic approach in a hemodynamically stable patient with persistent complaints. An exploratory laparoscopy is described in the literature as feasible and safe enough to evaluate the peritoneal cavity in these cases. Besides, is avoided the trauma of a sometimes unnecessary laparotomy. (3)