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Case Report

Intussusception in pregnancy

Gaddi Suman S

Danamma Hospital, Bellary

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Introduction

Intestinal obstruction is a rare event during pregnancy but when it occurs it carries serious maternal and fetal morbidity and mortality. Its incidence ranges from 0.067% to 0.0015%[1] . Intussusception accounts for 6% in pregnant women [1]. Another factor contributing to the difficulty in the diagnosis despite the specific radiographic finding is the superior displacement of the small bowel by the enlarged uterus. Therefor a high index of suspicion is mandated in this patient population. Treatment intervenrtions include aggressive fluid resuscitation to ensure uterine blood flow and to optimie fetal vibaility, electrolyte and acid-base in balance correction, gastrointestinal decompression by nasogastric intubation, and antibiotic prophylaxis.

Case report

Mrs. Peerabee an 18 year old woman was admitted to our hospital on 8th May 2005. She was a primigravida who gave a history of five months of amenorrhea, epigastric pain and vomiting which was acute on onset since one day. She was married for 10 months. She had no antenatal checkup till date. Her last menstrual period was not known. Past history and family history were not significant. On examination she had a toxic look and mild pallor was present. She was afebrile. Blood pressure was 120/60 mmHg and pulse rate was 108 beats per minute.

On abdominal examination the uterus was 20 weeks in size. There was fullness in the epigastric region and bowel sounds were exaggerated.

Her hemoglobin was 8.0 g/dL, blood group 'A' Rh: positive, white cell count 12500/mm^3, neutrophils 64%, lymphocytes-36%, eosinophils-2%, monocytes -0%, erythrocyte sedimentation rate-55 mm lst hour and coagulation profile within normal limits. Urine examination revealed nothing significant. Ultrasound examination showed 6x4cm mass in the right iliac fossa and free fluid in the peritoneal cavity suggestive of intestinal intussusception, with a live pregnancy of 20 weeks. A laparotomy was done under general anesthesia. At 52 cm proximal to the ileocecal junction there was an ileoileal intussusception 15-20cm in length (Figure 1). After the intussusception was reduced, a Meckel's diverticulum was detected (Figure 2). It appeared to be the cause of intussusception. The length of the reduced intestine was looking ischemic. Hence the resection including Meckel's diverticulum and the end to end anastomosis was done. A drain which was kept postoperatively was removed on the 5th

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Correspondence :
Dr. Gaddi Suman S
Danamma Hospital,
135, Kolachalam Compound
Opp. Royal Bus Stand,
Bellary 583101, Karnataka

postoperative day and sutures on the 10th postoperative day. Unfortunately she aborted spontaneously on the 13th postoperative day. She was discharged on the 15th postoperative day. On followup after one month her general condition was satisfactory.

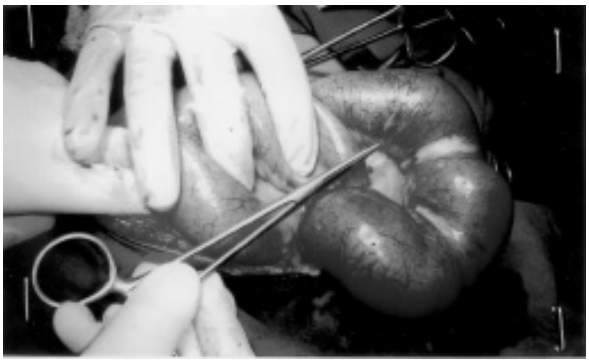

Figure 1. Showing the site of intussusception.

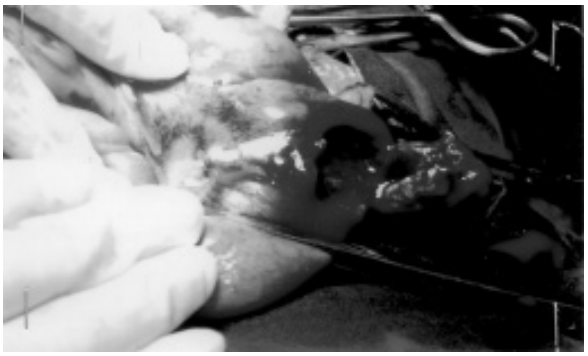

Figure 2. showing Meckels diveticulum.

Discussion

Abdominal pain during pregnancy has many causes including acute appendicitis, enterocolitis, intestinal obstruction, renal colic, constipation, ovarian torsion and placental abruption. Among these intestinal obstruction is a rare condition. Intussusception is one of the important causes of intestinal obstruction. Recognition of the condition is difficult because of the common symptoms of nausea, vomiting, occasional pain in the abdomen and constipation often seen during normal pregnancy. The most common type of intussusception occurring in pregnancy or puerperium is ileocecal.

Although intestinal neoplasms are the most common predisposing causes of adult intussusception, Meckel's diverticulum is the most common predisposing causes of intussusception. Meckel's diverticulum is the most common precipitating factor of intussusception in pregnancy [1]. Other causes of intussusception are hamartomatous polyp in jejunum, neurilemoma, lymphoma and colon cancer [2].

The classic sonographic finding of intussusception is multilayered, nonhomogeneous, complex and laminated appearance. Sonography is and the best diagnostic modality in diagnosing intussusception[1,3].

Immediate aggressive medical care within the first 24 hours is necessary in view of the high incidence of necrotic bowel in intussusception. Once intussusception is suspected, emergency measures should be initiated. Untreated intussusception is almost always fatal. There is an increased chance for death if this disorder is not treated within 48 hours.

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