

(CASE STUDY)

An unusual case of DJ bending obstruction in adult men

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Abstract

Well known as incomplete rotation also refers to a rotation of 270 degrees around superior mesenteric vessels. It can lead to chronic and acute disease presentations. It is an unusual case of 44-year-old male diagnosed with Gut malrotation with Duodenojejunal Flexure obstruction.

Keywords: Rotation; Flexure; Rare; Obstruction; Chronic; Duodenojejunal

1. Introduction

Birth deficiency is intestinal malrotation. There is no known cause of intestinal malrotation. Birth defect causing an intestinal tract malformation where the intestine doesn't turn right as it grows. This induces a blockage that prevents food from passing into the intestine [1]. The blood flow to the twisted section of the stomach can be cut off to destroy the portion of the intestine. For around 1 out of 500 births malrotation occurs. In new-born's and young children, malrotation is commonly diagnosed; up to 75% of symptomatic cases occur in neonates, while 90% of cases occur during the first year of life [2]. The real effect of malrotation in the older population is hard to quantify, as the majority remain asymptomatic throughout their lives. This may not be symptomatic before puberty or adulthood, but it is very rare in adults [3]. Medical conditions may include abdominal tenderness or distention, diarrhea, sprays of dark green fluids, bloody and dark red stools, constipation or trouble in expelling stools. Stool culture, high GI examination, CT scan, barium enema monitoring, blood testing, and versatile sigmoidoscopy [4,5] are diagnosed. Surgery typically leads to a positive outcome [6].

2. Case report

A 44 years old male patient was admitted in Intensive care unit, at Primary care hospital, Coimbatore with the chief complaints of stomach pain for four days along with nausea and three episodes of vomiting in green color. His vital reports were found to be normal. His laboratory investigations were done on day of admission and depicted in Table 1. He was diagnosed with Gut malrotation with Duodenojejunal Flexure. On day 1 he was treated with Intravenous fluids such as ringer lactate, normal saline and Isolyte M each of 100ml/hr, along with Inj. Pantocid (pantoprazole) 40 mg IV OD, Inj. Cefotaxime 1 g IV STAT, Inj. Ondansetron 4 mg IV OD, Inj. Enclarforte (cefoparazone+salbactam) 5 mg IV BD.

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Table 1 Laboratory investigations of patient

Investigation Parameters	Patient observed value	Normal value
Haemoglobin(Hb)	13.3 g/dl	14-18g/dl
Total count (TC)	7740 x10 ³ cells/mm ³	3.2-9.8 x10 ³ cells/mm ³
Polymorphs	77%	54-62%
Lymphocytes	14%	25-33%
Monocytes	08%	3.7%
Random blood sugar (RBS)	96 mg/dL	<200 mg/dL
Sodium (Na)	132 mEq	135-147mEq
Potassium(K)	4.2 mEq/L	3.5-5mEq/L
Blood urea (BU)	19 mg/dl	20-40mg/dl
Serum creatinine (Sr.cr)	0.9 mg/dl	0.6-1.2mg/dl
Bicarbonate	25	
Chloride	93 mEq/L	95-105mEq/L
Calcium	9.3 mg/dl	8.8-10.2mg/dL

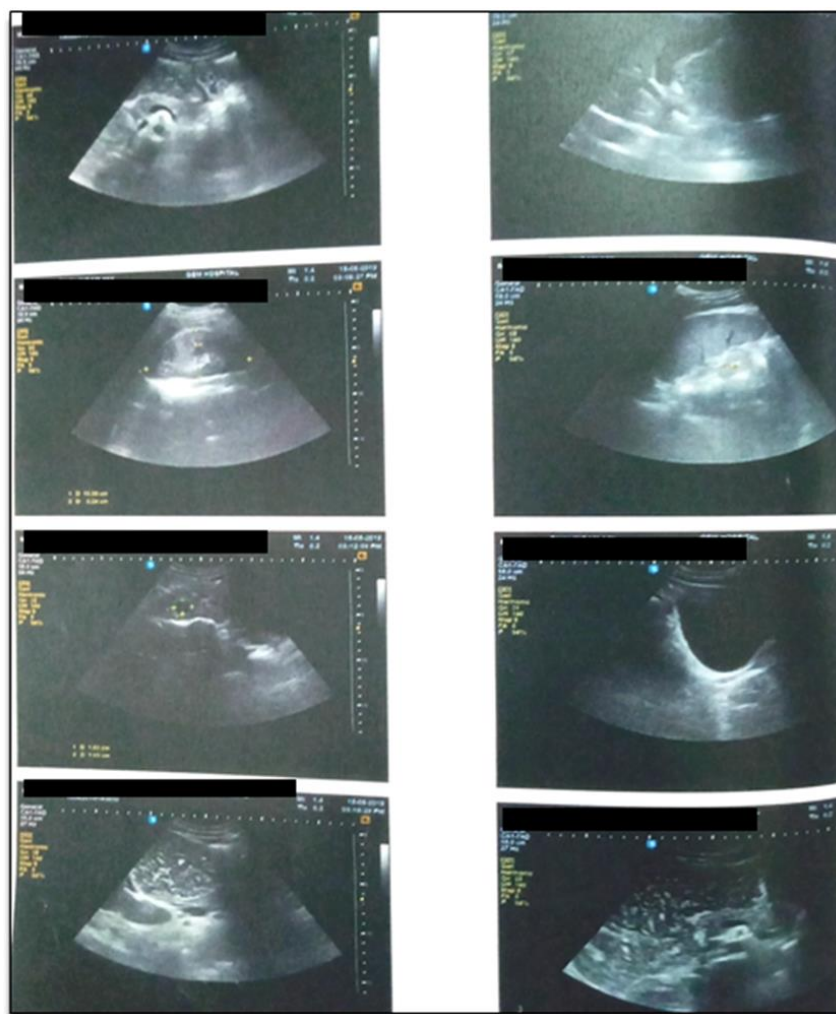


Figure 1 ECHO report

On day 2, at examination patient was conscious, oriented and afebrile. Vitals were normal and asked to continue the same medications. He was advised to take MRI, UG Scopy, ECHO and Ultra sound. On day 3, patient was conscious and afebrile. Patient was continued with ringer lactate, normal saline and dextrose normal saline each of 100ml/hr by IVF and followed with Inj. Lansuride (levosulpiride) 25 mg IV BD, Inj. Ornidazole 500mg IV BD, Inj. Perfulgan(paracetamol) 1g IV TDS, Inj. Enclarforte (cefoparazone+salbactum) 1.5g IV BD, Inj. Pantocid (pantoprazole) 40mg OD, and Inj. Clexane (Enoxaparin sodium) 0.4ml SC. Patient was treated with same medications for four more days added with T. Erythromycin 500mg BD. His ECHO report is presented in Fig. 1, UG Scopy report in Fig. 2 and Ultrasound report in Fig 3. And he was discharged with Tab. Cepodem (Cefpodoxime) 200mg BD, Tab. Pantoprazole 40mg OD, Tab. Ultracet (Tramadol+Acetaminophen) 650mg SOS, Tab. Multigate OD, Tab. Erythromycin 500mg OD, Tab. Domstal (Domperidone)10mg BD and Lactifiber powder 2TSP OD. Patient consent was taken for publishing his data.



Figure 2 UG Scopy of the patient reveals the obstruction of DJ flexure

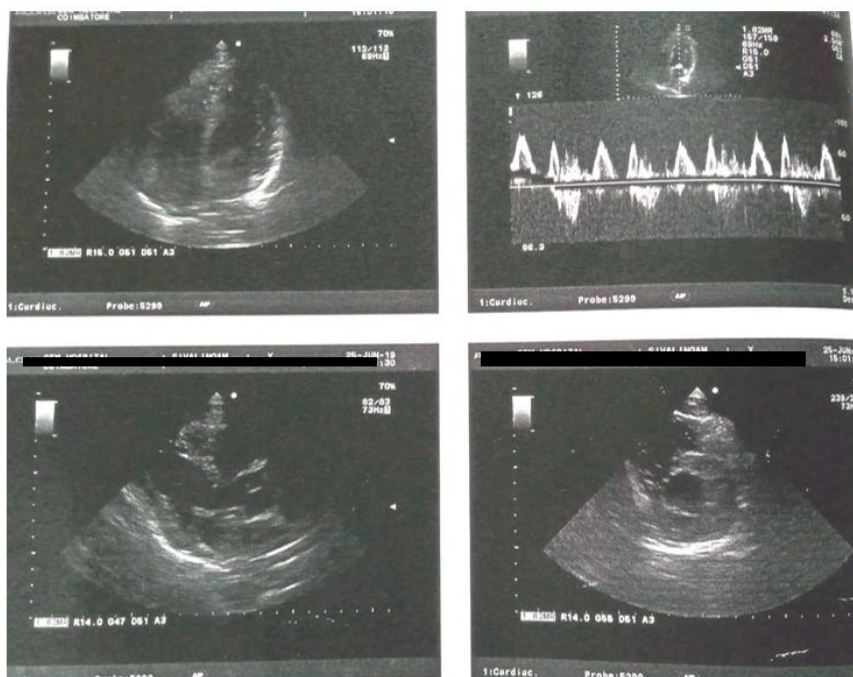


Figure 3 Ultrasound reveals the gut malrotation

3. Conclusion

Our patient was treated with pharmacy management for his main problems and condition. Ladd's treatment should have been performed to help the patient. This form of case is very rare and more information is required for confirmatory testing and care. Just a few cases have been reported in the literature.

Compliance with ethical standards

Acknowledgments

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Disclosure of conflict of interest

The authors declare none.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

References

- [1] Applegate KE, Anderson JM, Klatte EC Intestinal malrotation in children: a problem-solving approach to the upper gastrointestinal series. *Radiographics* 2006; 26(5):1485-1500.
- [2] Pickhardt PJ, Bhalla S Intestinal malrotation in adolescents and adults: spectrum of clinical and imaging features. *AJR Am J Roentgenol* 2002; 179(6):1429-1435.
- [3] Strouse PJ Disorders of intestinal rotation and fixation ("malrotation"). *Pediatr Radiol* 2004; 34(11):837-851.
- [4] Applegate KE. Evidence-based diagnosis of malrotation and volvulus. *Pediatr Radiol*.2009 Apr;39 Suppl 2:S161-3
- [5] Kumar N, Curry JI Bile-stained vomiting in the infant: green is not good! *Arch Dis Child Educ Pract Ed*. 2008 Jun; 93(3):84-6.
- [6] Friedland GW, Mason R, Poole GJ Ladd's bands in older children, adolescents, and adults. *Radiology* 1970; 95:363–368.