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A RARE CASE OF SMALL BOWEL OBSTRUCTION POST CAESAREAN SECTION

Medical Science

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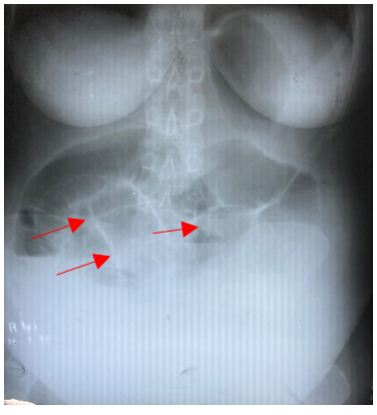
KEYWORDS

INTRODUCTION:

- Small bowel obstruction, is a rare complication following cesarean section, due to herniation of bowel through the rectus sheath.
- This is a case of uncomplicated primary cesarean section. The incidence of small bowel obstruction after caesarean section is very low.
- In a population-based cohort study, the risk of small bowel obstruction among women with a cesarean delivery was 16.3/10,000 person-years versus 6.4/10,000 person-years in women without caesarean delivery (odds ratio [OR] 2.54, 95% CI 2.15-3.00); and an increasing number of cesarean deliveries was associated with an increasing risk of small bowel obstruction (OR 1.61, 95% CI 1.46-1.78, per additional cesarean delivery)(1).

CASE REPORT:

- A 28 yr old G2P1L1 previous normal delivery with uneventful antenatal period underwent caesarean section at 38wks for CPD due to big baby (estimated wt 4300+/-577).
- LSCS was performed under spinal anaesthesia delivered 4.35 kg male baby through pfannensteil incision and kerr's uterine incision.
- Uterus sutured in two layers with catgut, hemostasis secured.
- Parietal peritoneum closed with catgut, rectus sheath sutured with monofilament polyamide, skin closed in mattress sutures with silk.
- After 16 hrs of surgery, bowel sounds were present, oral feeds started.
- On POD- 3 she developed abdominal distension
- X-ray erect abdomen showed multiple distended small bowel loops -s/o small bowel obstruction.
- Ultrasonography shows distended small bowel loops. Intestinal obstruction at distal jejunal or ileal bowel.

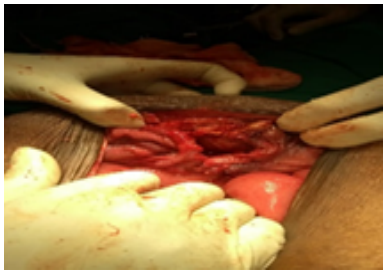


Multiple dilated, air-fluid filled bowel loops

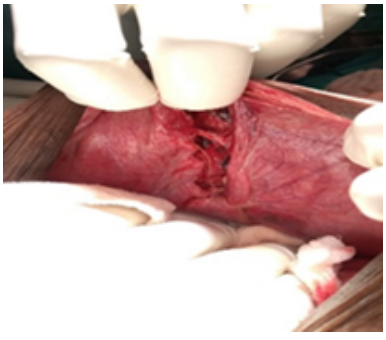
Emergency laparotomy was performed

Intra OP finding

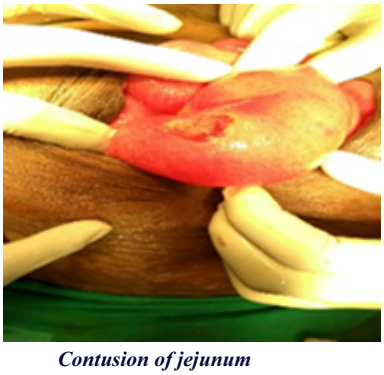
- A small defect of size 3*3cms in the rectus sheath located just below umbilicus in mid line far away from the suture line.
- A 6 * 3 cms defect noted in the peritoneal layer in midline below the umbilicus
- Loop of jejunum seen through the defect. Contusion of jejunum present.
- LSCS rectus sheath sutures are intact.



Rectus sheath defect 3*3cms



Parietal peritoneum 6 *3 cms



Contusion of jejunum

- Jejunum was reduced as no signs of ischemia noted.
- Parietal peritoneum closed with 1-0 vicryl.
- Rectal defect was repaired with 1 prolene.
- Post operatively patient recovered well, on POD 3 orals started.
- LSCS sutures removed, wound healthy.
- During Post-operative period, developed wound infection, acinetobacter isolated, treated with antibiotics

DISCUSSION:

- Most common cause of small bowel obstruction (SBO) after any surgery is due to adhesions and odema.(2,3)
- Ogilvie's syndrome (acute colonic pseudo obstruction)(4,5) and paralytic ileus(4) are two functional bowel obstructions common in obstetrics.
- Caesarean section and spinal anaesthesia are the etiological

factors.(4)

- An unusual case of small bowel obstruction post caesarean section reported due to non-closure of peritoneum in 2011(6)
- A randomised study- CESAR study on caesarean section surgical techniques revealed no difference in closure or non-closure of peritoneum(7)
- Both functional obstructions managed conservatively with nasogastric tube insertion, intravenous fluids, non-opiate analgesics and rectal laxatives.
- If the patient condition worsens laparotomy is done.
- The incidence of relaparotomy after CS was 1.04%. The most common indications for CS were hemorrhage and infections. Placenta previa, fetal macrosomia and emergency cesarean delivery were the best predictor of relaparotomy after CS. (8)
- Small bowel obstruction is a rare postoperative complication with rectal sheath defect and an incidental intraoperative finding.
- Small bowel obstruction should be operated in failed conservative measures to prevent life threatening complications, severe morbidity and mortality.

	PARALYTIC ILEUS	ACUTE COLONIC PSEUDO-OBSTRUCTION	MECHANICAL OBSTRUCTION
Symptoms	Mild abdominal pain, bloating, nausea, vomiting, obstipation, constipation	Crampy abdominal pain, constipation, obstipation, nausea, vomiting, anorexia	Crampy abdominal pain, constipation, obstipation, nausea, vomiting, anorexia
Physical examination	Silent abdomen, distention, tympanic	Borborygmi, tympanic, Peristaltic waves, hypoactive or hyperactive bowel sounds, distention, localized tenderness	Borborygmi, peristaltic waves, high pitched bowel sounds, rushes, distension, localized tenderness
Plain radiographs	Large bowel and small bowel dilatation, diaphragm elevated	Isolated large bowel dilatation, diaphragm elevated	Bow- shaped loops in ladder pattern, paucity of colonic gas distal to lesion, diaphragm mildly elevated, air-fluid levels

(9,10)

CONCLUSION:

- During post-operative period, meticulous systemic examination of the patient to be done till discharge to prevent unforeseen complications.
- In case of this type of unforeseen complications in the post-operative period, active medical or surgical management to be initiated at once.

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