

## **Large bowel obstruction from 'adhesions'**

### Author

Ng, Bertrand, Chua, Terence C

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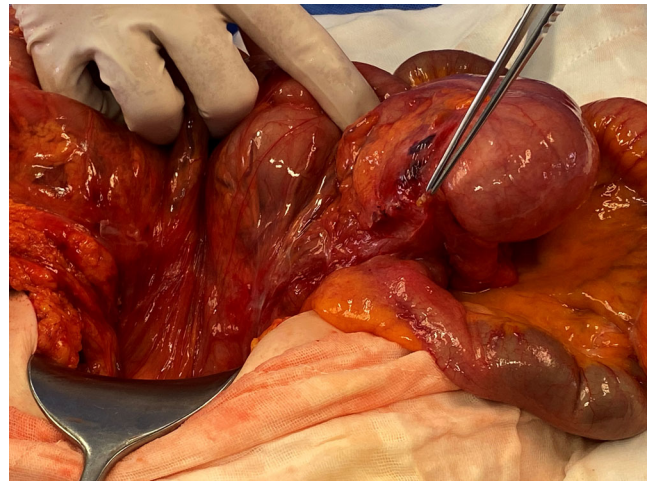
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## Large bowel obstruction from ‘adhesions’

A 76-year-old woman presented to the hospital with 4 days progressive intermittent right sided abdominal pain that became constant. She has been nauseous and vomited on multiple occasions and was obstipated. Her past medical history includes atrial fibrillation and a previous open midline scar hysterectomy with lymph node dissection for endometrial cancer many years ago. On examination, her right abdomen was distended compared to her left with localized guarding over her right lower quadrant. Her observation was within normal limit. Electrocardiogram showed sinus rhythm. Her white cell count and lactate were normal. A contrast-enhanced computed tomography (CT) imaging demonstrated loop of non-enhancing thick wall and dilated caecum and dilatation of the ascending colon (Fig. 1). The patient proceeded to an emergency laparotomy. Intraoperative findings reveal a thick adhesive band between the ileocolic mesentery and the right pelvic sidewall and a resultant internal hernia from the redundant right hemi-colon through this adhesive band (Fig. 2). The band adhesion was divided with scissors relieving the large bowel obstruction. The large bowel appeared viable following an abdominal lavage and the



**Fig. 1.** Computed tomography abdomen and pelvis imaging at time of this presentation, demonstrating thick wall ascending colon up to the level of the hepatic flexure.



**Fig. 2.** Intraoperative photo with forceps showing one end of the band that was released.



**Fig. 3.** Intraoperative photo showing mobile colon that was eviscerated out of the abdominal cavity.

right-hemi-colon was pexied at two points using a 3/0 PDS suture to anchor it to the retroperitoneum. The patient recovered well and regained bowel function by the third postoperative day and was discharged home on day 7.

Approximately 10–20% of people are thought to have a mobile ascending colon based on autopsy studies.<sup>1</sup> Congenital mobile ascending colon is hypothesized to occur due to a defect in fixation to the retroperitoneum during midgut development, whereby failure in fusion of the ascending colon mesentery to the posterior parietal peritoneum results in the ascending colon retaining a long mesentery.<sup>2</sup> Commonly, the redundant caecum and ascending colon are at risk of volvulus which is the most common pathology that occur.<sup>3</sup> The precipitating condition that resulted in this occurrence in our patient was the congenital abnormal redundant mesentery of the colon and failure of attachment of the colon to the retroperitoneum that allowed the mobile colon to slide through an adhesive band that formed from previous surgery. As shown in Fig. 3, the entire colon was easily eviscerated into the laparotomy wound without performing any mobilization of the colon's retroperitoneal attachments. In summary, early surgical assessment and imaging together with sound decision making of early surgery avoided the dreaded scenario of irreversible ischaemia and gangrene in a very unusual and atypical cause of large bowel obstruction.

## Informed consent

Informed consent was obtained from the patient for permission to present this case for an educational purpose in an anonymous manner.

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## Author contributions

**Bertrand Ng:** Conceptualization; data curation; formal analysis; writing – original draft; writing – review and editing. **Terence C. Chua:** Conceptualization; data curation; supervision; writing – review and editing.

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Bertrand Ng,\*† MBBS

Terence C. Chua,\*†‡ MBBS, PhD, FRACS 

\*Department of Surgery, Queen Elizabeth II Jubilee Hospital, Brisbane, Queensland, Australia, †School of Medicine, The

University of Queensland, Brisbane, Queensland, Australia and

‡School of Medicine, Griffith University, Gold Coast, Queensland, Australia

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