VOLUME-8, ISSUE-11, NOVEMBER-2019 • PRINT ISSN No. 2277 - 8160 • DOI : 10.36106/gjra

Original Research Paper

General Surgery

A CASE REPORT: A RARE CASE OF PEUTZ JEGHER POLYP PRESENTING AS SMALL BOWEL INTUSSUCEPTION.

Dr Rajesh D Patel MS Assistant Professor, Department of General Surgery, B .J Medical College, Ahmedabad.

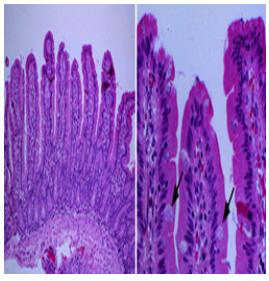
Dr Jigarkumar J Modi* MBBS 3rd Year Resident, Department of General Surgery, B .J Medical College, Ahmedabad. *Corresponding Author

KEYWORDS :

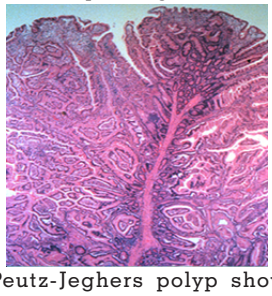
INTRODUCTION

Peutz-Jeghers syndrome (PJS) is rare with an estimated prevalence of 1:8000 to 1:200,000 births. Males and females are equally affected. Autosomal dominant disorder (1 per 200,000) with variable penetrance, usually diagnosed at age 20 – 30. Hamartomatous polyps in small bowel (100%), stomach and colon (25%) - polyps may occur without other features of syndrome, may cause intussusception and bleeding. Polyps are benign but adenocarcinoma may arise from associated adenomatous lesions.

H&E SLIDES OF PEUTZ JEGHER'S POLYP



Low (left) and high (right) power views of the normal villous architecture of the small intestine. The high power view shows the enterocytes and interspersed goblet cells (arrows).



A duodenal Peutz-Jeghers polyp shows a tree-like proliferation of smooth muscle lined by normal small intestinal epithelium; the overlying epithelium is normal

Case Report

- A 24 Years Old Hindu Male Patient Came In Our Emergency With Chief Complain Of :- Generlised Abdominal Pain Since 2 Days, Vomiting Since 2 Days, Abdominal Pain, Was Generalised, moderate In Intensity, aggravated With Taking Meal And Was not Relieved With Medication, not Radiating To Any Other Site. Also Vomiting, 2-3 Episodes In 2 Days ,non Projectile, non Billious, containing Food Particles ,occurs After 1-2 Hours After Meal. No C/o Fever, diarrhoea, bleeding P/r,malena,constipation,burning Micturition. No History Suggestive Of Dm, htn, tb, jaundice, Previous Surgeries, Blood Transfusions. Patient Had No Addictions. No Significant Family History.

On General Examination,

- Pulse-92/min
- Bp- 100/60 Mm Hg
- Rr-22/min

On Per Abdomen Examination:

- Patient Had Generalised Tenderness Present All Over The Abdomen

On Per Rectum Examination:

- No E/o Anal Fissures Or Fistulas
- No Bleeding Per Rectum

Investigations

- Complete Blood Count, Viral Screening, Coagulation Profile, Renal And Liver Function Tests And Serum Electrolytes Found To Be Normal.
- Abdomen Xray –s/o Multiple Air Fluid Levels
- Chest Xray – No Abnormality Detected
- Usg Abdomen + Pelvis :
- Approx 30*44 Mm Size Target Like Lesion(bowel Within Bowel Apperance) Seen In Pelvis.
- Large Bowel And Messentry Act As Intussuceptum And Large Bowel Act As Intusuccepient.
- Length Of Involved Segment Is 75mm And Findings Suggest P/o Colo-colic Intussuception.
- Patient Had Outside Cect Abdomen With Pelvis Report Which Was Suggestive Of :-
- Dilatation Of Large Bowel With A Maximum Diameter Of 5.5cm With Fat Stranding In Mesentery.
- Rest Of The Abdomen Had No Signitficant Abnormalities.

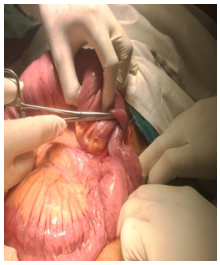
Plan Of Management

- After Initial Assessment, Resuscitation And Investigations, Pt Was Taken For Exploratory Laparotomy In Our Emergency Operation Theatre.

Operative Procedure

- Exploratory Laparotomy Through Midline Incision Was Done.
- An 8 Cm Skin Incision Was Placed On The Lower Midline Of Abdomen.
- After Incising Through The Anterior Abdominal Layers, Peritoneum Was Opened And Bowel Was Evacuated Out And Approximately 40cm From The Duodenojejunal Junction, Jejunojejunal Intussusception Was Found.

SMALL BOWEL INTUSSUSCEPTION



CUT SECTION OF RESECTED BOWEL SHOWING MULTIPLE POLYPS IN THE BOWEL LOOP

Intussusception Was Manually Reduced And A Palpable Mass Was Found At The Lead Point.

Enterotomy Was Done And Multiple Poypoidal Lesions Were Found In The 10 Cm Segment Of The Jejunum.

The Segment Was Resected And End To End Anastomosis Was Done In Two Layers Using *Silk 2-0*.

Approx 5cms Free Margins Were Kept On Either Side Of The Lesion.

A *32fr* Romo Adk Was Placed In The Pelvis And Fixed To Skin. Adequate Wash Given With Normal Saline.

Closure Was Done After Instrument Tally And Mop Count.

Post Operative Period

- Patient Was Monitored For 24 Hours And Was Then Shifted To The Wards.
- Nil By Mouth Regime Was Employed. Anitbiotics And Fluids Were Given Intravenously.
- Sips Were Started On The 3rd Post Operative Day After Patient Passed Stool And Flatus.
- Followed By Liquids And Then To Soft Diet Subsequently.
- Abdominal Drain Was Removed On 5th Post Operative Day.
- Pt Was Discharged After 5 Days Of Observatory Period.
- Skin Stitches Were Removed On 15th Post Operative Day

DISCUSSION

- Small Bowel Intussusception Is A Case Of Grave Urgency As It Will Lead To Intestinal Obstruction And Can Cause Ischemia And Subsequent Gangrene Of The Involved Bowel Loop.
- The Intra Enteral Mass Was The Causation Of Intussuscception And Acted As A Lead Point Which Caused Obstruction Of The Proximal Bowel.
- **Hpe** Examination Of The Resected Segment Of The Small Bowel With Polyps Revealed Well Differentiated Adenocarcinoma Infiltritating Into Submucosa And Reaching Upto Muscularis Propria With No Serosal Breach.
- Tumor Staging Was Done Which Was T1nxmx
- Modified Duke's Stage: B1
- Ajcc Stage : Group:1
- In This Case The Patient Was Referred To The Gcri(Gujarat Cancer And Research Institute) For Adenocarcinoma Of Small Bowel.
- A Review Of The Hpe Slides Were Done At The Gcri Which Was S/o *Peutz-jegher's Polyp*.
- No Evidence Of Malignancy Was Found.
- Patient Is Kept Under Regular **6 Monthly Follow Up At Gcri**.

REFERENCES:

1. bailey And Love's Short Practice Of Surgery.
2. sabiston Textbook Of Surgery.
3. devita,hellman And Rosenberg's Cancer Principles And Practice Of Surgery.