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Case Report

Acute Intestinal Occlusion by Ileo-Sigmoid Node: About a Case

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Abstract: The ileosigmoid node is a rare surgical emergency. We report a case of intestinal obstruction by ileosigmoid node that occurred in a young adult patient himself accompanying another patient. Management was early and confirmation was intraoperative.

Keywords: ileosigmoid node, medico-surgical emergency, diagnosis, rectal ampulla.

INTRODUCTION

The ileosigmoid node is a rare cause of bowel obstruction. It is a medico-surgical emergency whose diagnosis and treatment must be early.

The ileosigmoid node (NIS) or double ileosigmoid volvulus is a wrapping of the small intestine around the base of the sigmoid colon, thus obtaining an obstruction by bifocal strangulation of the sigmoid and ileum [1-3].

If its diagnosis is for the majority of cases per operative in a hospital environment, it is by far not suspected in a rural environment in a center with limited means. We report a case of ileo-sigmoid knot treated in a reference health center with limited resources.

OBSERVATION

This was a 43-year-old patient, farmer, with no particular medical-surgical history, who came for an ordinary consultation for sudden abdominal pain associated with food vomiting. The interrogation made it possible to find a notion of hypogastric pain in less than 24 hours, without triggering factors, of strong intensity with the type of torsion without irradiation with periods of calm associated with early post prandial food vomiting not streaked with blood or of bile, not abundant, a tympanic meteorism in a context of stopping of materials and gases. There was no fever.

On examination, the patient was conscious, the conjunctiva well colored, the temperature at 37°2C, the blood pressure at 11/7cmhg, the pulse at 93 beats/minute. The abdomen was deformed with a tympanic arch in the left flank and periumbilical region, a slight tusk in the hypogastric region.

On digital rectal examination, the rectal ampulla was empty; Douglas' cul-de-sac was free. The rest of the examination was unremarkable. The diagnosis of an occlusion by volvulus of the sigmoid colon was evoked and a preoperative assessment carried out which concluded with a hemoglobin level of 11g/dl, a grouping/Rhesus O+.

Our conduct was preoperative resuscitation and then an emergency laparotomy was performed. At the celiotomy, we discover a sero-hematic effusion of

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about 1.5 liters which we aspire; the exploration made it possible to find a winding of the ileum around the sigmoid in the clockwise direction creating an ileo-sigmoid node, an ileal sphacele (Fig 2, 4). There was no ileal or sigmoid necrosis (Fig 2). We performed ileal devolution associated with sigmoid resection followed by end-to-end colorectal anastomosis.

The postoperative follow-up was simple 6 days postoperatively and the patient was exec.

Fig 1: Peroperative Sigmoid Loop

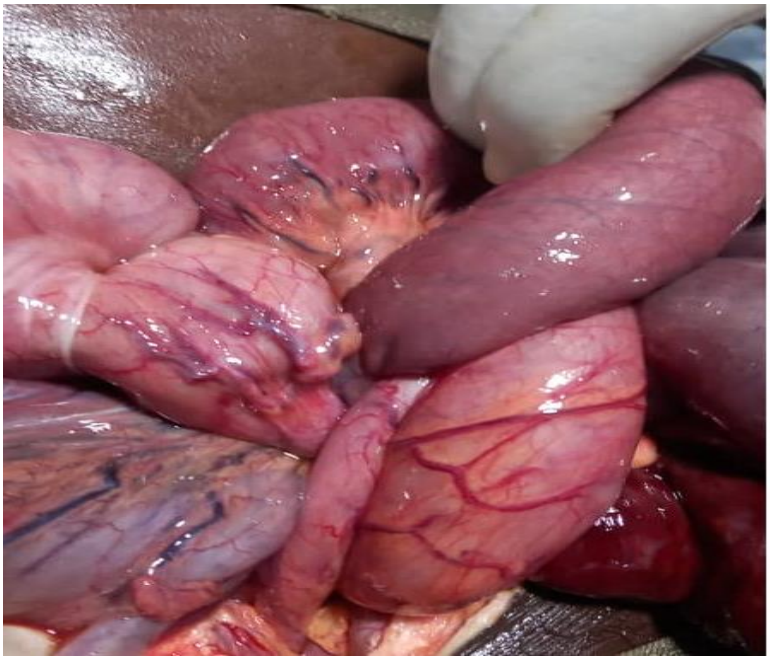

Fig 2: Ileal loop around the Sigmoid

Fig 3: Sigmoid colon freed from the ileal loop

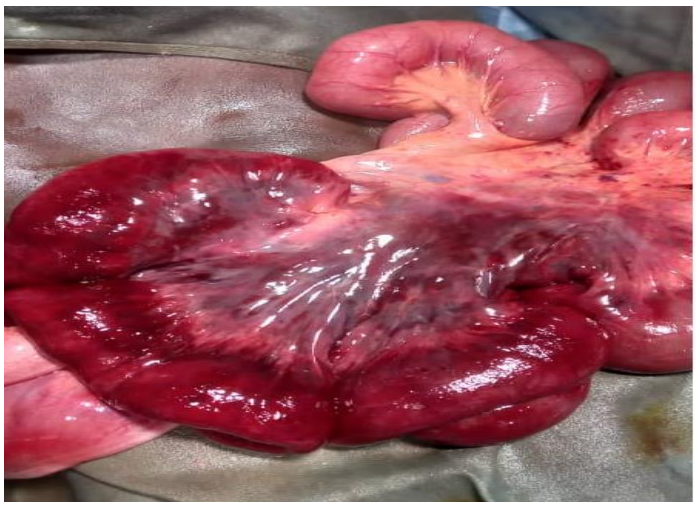

Fig 4: Aspect of the sphacelus small bowel

Fig 5: Appearance of the hail loop after devolution and recoloration

DISCUSSION

Ileosigmoid node (NIS) is a rare surgical emergency; it represents 7.6% of volvulus in France and 2.62% in Mali [4, 5].

The male sex around forty seems to be the most frequently affected according to the literature [2, 4, 6]; this agrees with our observation.

In our context, the patient was seen in an ordinary consultation, this is generally rare because occlusions constitute a surgical emergency and therefore for the most part admitted urgently. This is contrary to the literature [5, 7].

The occurrence of intestinal obstruction by ileosigmoid node has no prodrome; in particular, the ordinary consultation in our context was motivated by the role of the patient who was himself accompanying another patient.

The symptomatology, dominated by abdominal pain and vomiting with cessation of matter and gas, made it possible to evoke the hypothesis of intestinal obstruction as observed in the study by Maiga and Alokoutou [5, 7].

The x-ray of the abdomen without preparation and the scanner are sometimes necessary in front of such a table, they were not carried out in our context on the one hand because the diagnosis of occlusion was obvious, and on the other hand by absence especially since they rarely evoke specific signs of an NIS in rural areas [10, 11].

The occurrence of NIS is still hypothetical, but two contributing factors have been mentioned in the literature [7], in particular anatomical predispositions with a hypermobile small intestine, an excessively long meso or redundant sigmoid loops based on narrow implantation; and on the other hand the rapid replenishment of the jejunum in patients who eat only one meal a day which would favor its twisting around the empty ileum [8].

The NIS causes a complex intestinal obstruction by double strangulation of the mesenteric vessels of the small loops and the sigmoid, this mechanism, when it occurs and persists beyond 6 hours can quickly lead to ischemic necrosis [9].

In our observation, the diagnosis of intestinal obstruction was made early and treated (less than 2 hours). It was type I as defined by Alver [4] without necrosis, unlike the Alokoutou study which found ileal necrosis over 2 meters and sigmoid [7].

In the literature, NIS type I clockwise seems more frequent, which is consistent with our observation. Necrosis was absent in our case (Fig 4) tight as found in the Maiga study [5].

The operative tactic depends on the intraoperative lesional assessment, in our context, we performed ileal detorsion associated with sigmoid resection and end-to-end colorectal anastomosis; this was justified by the absence of intestinal necrosis (Fig 5) with stable hemodynamic conditions.

The postoperative course was simple and the patient was discharged after 6 days of hospitalization. Postoperative follow-up after 30 days was unremarkable.

CONCLUSION

The ileosigmoid node is a surgical emergency whose early management determines the prognosis. Diagnosis is mostly intraoperative. Ileal devolvulation and sigmoid resection associated with a one-stage anastomosis was our procedure.

REFERENCES

1. Arthur, V., Pascal, A., Hubert, R., Christophe, C., & Yves-Patrice, L. T. (2007). Le noeud ileosigmoidien: Une cause improbable d'occlusion intestinale primitive par strangulationbifocal. *Gastroentérologie Clinique et Biologique*, *31*, 975-977. *https://doi.org/10.1016/S0399-8320(07)78308-2*
2. Atamanalp, S. S., Ören, D., Başoğlu, M., Yıldırgan, M. İ., Balık, A. A., Polat, K. Y., & Çelebi, F. (2004). Ileosigmoidal knotting: outcome in 63 patients. *Diseases of the colon & rectum*, *47*, 906-910.
3. Boukhalit, H., Zamani, O., & Jroundi, L. (2019). A case of ileo-sigmoid node in a postpartum woman. *Pan Afr Med J*, *32*, 106.
4. Alver, O., Ören, D., Tireli, M., Kayabaşi, B., & Akdemir, D. (1993). Ileosigmoid knotting in Turkey: review of 68 cases. *Diseases of the colon & rectum*, *36*, 1139-1147.
5. Amadou, M., Ibrahima, D., Amadou, B., Boubacar, D. A., Bathio, T., Diassana, M., ... & Adégné, T. (2022). Diagnosis and Therapeutic Aspects of the Ileo-Sigmoidian Node in the General Surgery Department of Gabriel Toure Chu. *Surgical Science*, *13*(1), 23-27. *https://www.scirp.org/journal/ss*; DOI: 10.4236/ss.2022.131004
6. Korse, B. A., Naby, C. S., Christian, C. C., Lansana, C. F., Yaya, D. S., Habiboulaye, B., ... & Biro, D. (2021). Ileo-Sigmoidian Node: About A Case in the Visceral Surgery Department of the Donka National Hospital. *GSC Advanced Research and Reviews*, *9*(1), 179-184. DOI: https://doi.org/10.30574/gscarr.2021.9.1.0233, revised and accepted on 22 October 2021

7. Alokoutou, Y., Aliamutu, C. K., & Natta N'tcha, H. N. (2022). Acute intestinal obstruction by ileo-sigmoid node: about a case and review of the literature. *Jaccr Africa*, 6(2), 30-34.
8. El Majdoubi, H., Ben Moussa, M., & Baiss, M. (2020). Intestinal obstruction on ileo-sigmoid node in a postpartum woman: about a case and review of the literature. *Int J Med Rev Case Report*, 4(8), 14-17.
9. Journé, C., Ravard, C., Monneuse, O., & Pilleul, F. (2008). Ileosigmoid node: a surgical emergency. *J Radiol*, 89(12), 1947-1949.
10. Hirano, Y., Hara, T., Horichi, Y., Nozawa, H., Nakada, K., Oyama, K., ... & Kitagawa, K. (2005). Ileosigmoid knot: case report and CT findings. *Abdominal imaging*, *30*, 674-676.
11. Burrah, R., Menon, A., Pathan, H., Ravikanth, R., & Kilpadi, A. (2010). The ileosigmoid knot. *Indian Journal of Surgery*, *72*, 140-142.

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