A Rare Cause of Ileus: Napkin

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ABSTRACT

Foreign bodies are one of the rare cause of mechanical intestinal obstructions. 75 years old female patient presented to emergency department complaining about abdominal pain, nausea and vomiting. Patient underwent to surgery for mechanical intestinal obstruction. Obstruction due to necrosis in 30 centimeters of terminal ileum detected. Resection and end to end anastomosis performed. A napkin seen inside of the specimen. We are presenting a patient with mechanical intestinal obstruction due to a napkin.

Key words: Napkin, intestinal obstructions, ileus

INTRODUCTION

Ileus is an an important group of conditions causing acute abdominal pain. Typical clinical signs of ileus are abdominal pain, nausea, vomiting, and blockage of the passage of stool and gas (1). Napkin has never been known as a cause of alimentary tract obstruction. In the present case, the patient suffered from gastrointestinal obstruction due to a napkin in the ileum.

CASE

TA 75-year-old woman presented to the emergency department with abdominal pain, severe nausea, and vomiting. Physical examination revealed abdominal distention and diminished bowel sounds. Laboratory test results were as follows: sodium, 129 mEq/L (135–145 mEq/L); potassium, 4.3 mEq/L (3.6–4.8 mEq/L); blood urea nitrogen, 180 mg/dL (10–20 mg/dL); serum creatinine 3.2 mg/dL (0.4–1 mg/dL); and white blood cell count, 10,300 cells/mm^3. The patient had a past medical history of hypertension and diabetes mellitus for 20 years, coronary bypass for 10 years, and Alzheimer's disease for 3 years. Plain abdominal x-ray revealed dilated small bowel loops with air-fluid levels (Figure 1). Abdomen ultrasound revealed dilated bowel loops. Abdominal computed tomography demonstrated dilated ileal loops, suggestive of ileus, and a foreign body lodged in the terminal ileum, with wall thickening (Figure 2). The patient was hospitalized and hydrated with intravenous saline with potassium supplementation. She was referred to emergency operation. Operative findings showed adhesion and strangulation of the terminal ileum. A 30-cm necrotic segment of the intestinal tract was surgically removed. Macroscopic findings were a largely dilated small bowel proximal to a napkin present in the ileum (Figure 3). Histopathological examination of the ileum revealed necrosis. Intravenous metronidazole and ceftriaxone were administered for 10 days. After treatment, blood urea nitrogen, serum creatinine, and potassium were normal. The patient had a good postoperative course and was discharged on the 18th day following surgery.

DISCUSSION

Intestinal bowel obstruction is a common surgical emergency that causes a problem in abdominal surgery. The leading causes of small bowel obstruction are postoperative adhesions (60%) followed by malignancy, Crohn disease, gallstone

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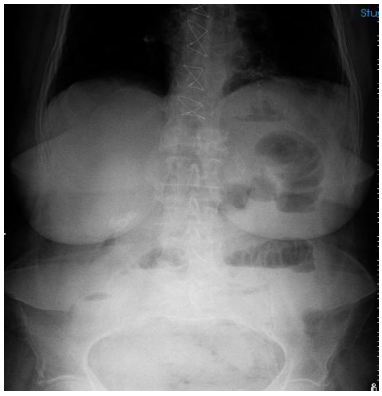

FIGURE 1: Abdominal x-ray revealed dilated small bowel loops with air-fluid levels.

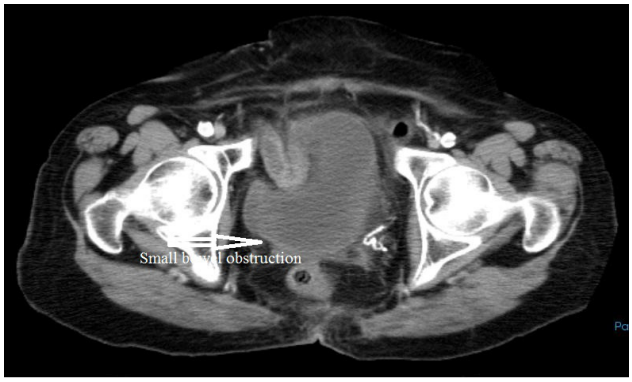

FIGURE 2: Abdominal computed tomography image revealed a napkin in the distal ileum and dilated loops of the small bowel.

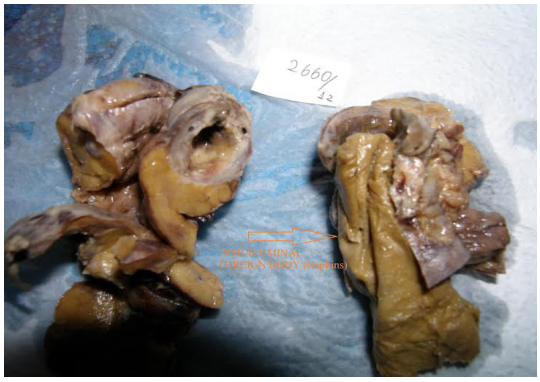

FIGURE 3: Intraluminal napkin.

ileus, hernias in anomalous recesses (prevesical, left paraduodenal, and paracecal hernias), and bezoar or foreign body, as in the present case (2-4). Patients with ileus typically have vague, mild abdominal pain and bloating. They may or may not continue to pass flatus and stool, as in the present case. The abdomen may be distended and tympanic depending on the bowel distention. A distinguishing feature is absent or hypoactive bowel sounds, as in the present case. Patients with ileus should receive intravenous hydration. Underlying electrolyte abnormalities may worsen ileus. These contributing conditions are corrected, and the patient is referred to the operation, as in the present case (2-3).

CONCLUSION

The differential diagnosis of ileus should include tracing the presence of a napkin, if any, in the ileum.

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