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JEJUNO-ILEAL DIVERTICULITIS IN AN ELDERLY PATIENT - CASE REPORT

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Abstract: Diverticular disease of the small intestine is an uncommon and little diagnosed disease, as it presents non-specific symptoms. However, some cases may develop complications from the disease, requiring surgical treatment.
We report here a case of jejunal diverticulitis, diagnosed using abdominal tomography and treated surgically at our institution.
Keywords: Jejunal diverticulitis; Diseases thin; Intestinal perforation; Complications

INTRODUCTION

Jejunoileal diverticulosis is a rare disease, occurring in 1 to 2% of the general population. It is more common in males and the prevalence increases with age, being higher in the 6th and 7th decades of life[1].

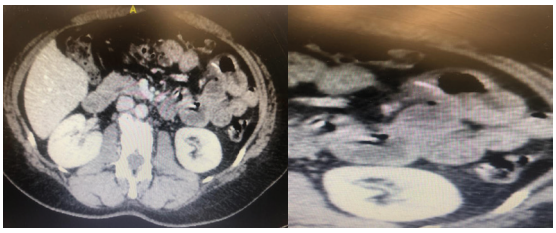
Most of the time, small bowel diverticulosis is asymptomatic and can be seen as an incidental finding on imaging tests. It must always be part of the differential diagnosis of abdominal pain, especially in the elderly. When symptomatic, in most cases, it presents as acute diverticulitis.[2]

CASE REPORT

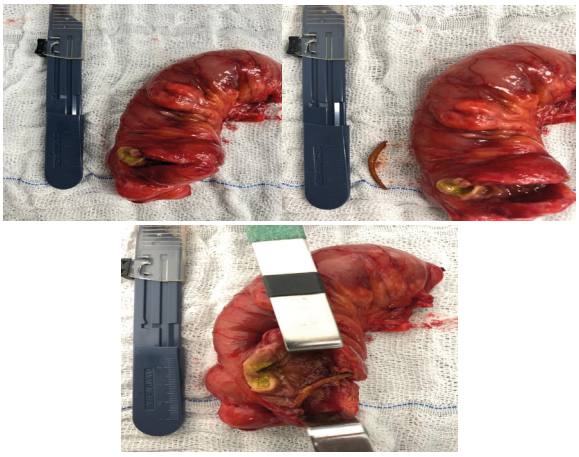
Patient, female, 66 years old, hypertensive and dyslipidemic, is admitted to the ER with

Complaint of abdominal pain that worsens when eating, associated with nausea, which started 4 days ago. On examination, the patient was hemodynamically stable and had pain on palpation in the right flank without signs of peritoneal irritation.

Perform a CT scan of the abdomen which shows elongated dense material, measuring approximately 27 x 2 mm, in a segment of the small loop on the left flank, determining probable perforation of this loop segment, with edema of the local adipose planes (fish bone?). Absence of lymph node enlargement, collections or pneumoperitoneum. Sparse colic diverticula, without inflammatory signs.



She underwent exploratory laparotomy where a blockage was identified in the left flank, with no free fluid in the cavity. Once the blockage was removed, a small diverticulum was found with inflammatory signs, perforated by a chicken bone 65 cm from the Treitz, and diverticula along the entire length of the small part (these without inflammatory signs). We then opted for enterectomy of the segment and side-to-side anastomosis with a 75mm TLC stapler.



The patient presented good postoperative evolution and was discharged 4 days later.

DISCUSSION

Jejunoileal diverticulosis was first described by Soemmering and Baille in 1794[5]. Jejunoileal diverticula are classified as false diverticula or pseudodiverticula, as they have only the mucosa and submucosa layers. The jejunum is the most frequently affected segment. Association with diverticular disease of the colon occurs in 35% to 75% of cases. [2,3]

Inflammatory acute abdomen, secondary to acute jejunoileal diverticulitis, is caused by two main factors: stasis of intestinal contents within the diverticulum and mucosal edema, which obstructs the diverticular neck, favoring mucosal ischemia, microperforations and polymicrobial growth. [2].

There is no consensus regarding the ideal treatment. Many studies have established that non-operative treatment can be successful even in patients with blocked perforation [1,3]. Hemodynamically stable patients with uncomplicated acute diverticulitis must receive treatment according to institutional sepsis protocols (hemodynamic resuscitation and early parenteral broad-spectrum antibiotic therapy). Surgical intervention must be reserved for cases with persistent symptoms, diffuse peritonitis, hemodynamic instability or organic dysfunctions. Blocked collections can be drained by minimally invasive methods such as ultrasound- or CT-guided percutaneous drainage, similar to colonic diverticulitis. It has also been demonstrated that laparoscopic access is safe and effective. [2].

Surgery is indicated in patients with diverticulitis complicated by intestinal perforation, fistula or abscess and in patients with refractory gastrointestinal bleeding. This may require laparotomic or laparoscopic resection of the involved segment, depending on local conditions, anatomical difficulties or clinical status of the patient.[4]

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