ABDOMEN AGUDO OBSTRUCTIVO EN EL EMBARAZO INTESTINAL OBSTRUCTION IN PREGNANCY

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RESUMEN:

Objetivo: Realizar una revisión de literatura científica de carácter descriptiva y a la vez reportar el caso clínico de abdomen obstructivo durante el embarazo.

Descripción breve: Se trata de una paciente femenina de 26 años de edad que curso con Embarazo de 35 semanas por FUM, acude a emergencias por presentar distención abdominal, dolor y historia de constipación, se decide realizar laparotomía exploratoria previo a culminación del embarazo mediante cesárea, encontrando vólvulo de sigma resolviendo el caso con colostomía.

Conclusiones: el embarazo complicado con obstrucción intestinal es raro, con una incidencia de entre 1/5000 y 1/66000 pacientes. El vólvulo intestinal es responsable del 25% de la obstrucción aguda, con mayor importancia dichos casos cursan con una mortalidad materna del 6% y mortalidad fetal del 26%.

PALABRAS CLAVES: vólvulo de sigma, abdomen agudo, obstrucción intestina, embarazo

KEYWORDS: sigmoid volvulus, acute abdomen, intestinal obstruction, pregnancy

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INTRODUCTION:

Pregnancy with intestinal obstruction is relatively rare, when it occurs with intestinal ischemia it endangers the life of the mother and the baby, so its prompt diagnosis and treatment is important. Ultrasound and MRI are most commonly used to establish the diagnosis, however the information obtained is usually limited other than the patient cannot cooperate with MRI due to the long time required for this examination.

Regarding Tomography, it is the most accurate test to identify intestinal lesions, its use during pregnancy is controversial due to fetal radial exposure, since according to some studies the fetal dose that causes damage to the nervous system, malformations and cancer must exceed the 100 mGy. Since CT, the radiation dose is usually less than 100 mGy, it is usually used more frequently. It should be used after excluding other causes (such as cholecystitis, appendicitis, urinary system and obstetric factors).

For patients with mild symptoms, MRI or ultrasound may be selected.

Regarding treatment, the objective is to resolve the obstruction. If there is no intestinal ischemia or sepsis, placement of a nasogastric tube or rectal tube is chosen with the objective of gastrointestinal decompression. In addition to symptomatic relief, the use of oral laxatives and antispasmodics.
In the case of signs of intestinal ischemia, a more invasive approach requires emergency resolution due to the vital risk for both the mother and the fetus. All this depends on how advanced the pregnancy is, so the behavior is established according to the weeks of gestation: before 28 weeks of gestation, an attempt should be made to solve the obstruction while maintaining the pregnancy, but not after 32 weeks, surgery Digestive surgery should be performed after an emergency cesarean section.
However, if the pregnancy is between 28 and 32 weeks of gestation, it must be determined whether the pregnancy should be terminated based on fetal development and the condition of the pregnant woman. All of this must be carried out along with the obstetric-gynecological assessment of the patient and, if applicable, consider the use of doses for fetal maturation.

DEVELOPING

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This is a 29-year-old patient who came to the emergency department with a history of constipation and abdominal pain for 5 days without apparent cause, she denies any significant medical or surgical history, she had 2 prenatal check-ups every month, and she was pregnant for 35 years. weeks without complications until that moment. Oral laxatives are used in the first instance with no response within 24 hours, the pain persists and worsens. Physical examination revealed a pregnant woman with a distended and painful abdomen. Fetal monitoring showed no evidence of fetal distress. Computed tomography (CT) of the abdomen and pelvis was performed. It revealed an obstruction of the large intestine. A transition point was observed at the level of the sigmoid colon. There was no free intraperitoneal gas, it was decided to perform an emergency cesarean section and subsequent abdominal laparotomy. Obtaining the following findings: female newborn that weighed 2150 g and was admitted to neonatal intensive care. Exploratory Laparotomy: sigmoid volvulus, area of necrosis at the level of the sigmoid colon and hypoperfused areas, resection of the area of necrosis and subsequent colostomy are performed. The postoperative period ended without incident and the patient was discharged home on postoperative day 4 with a functioning colostomy.

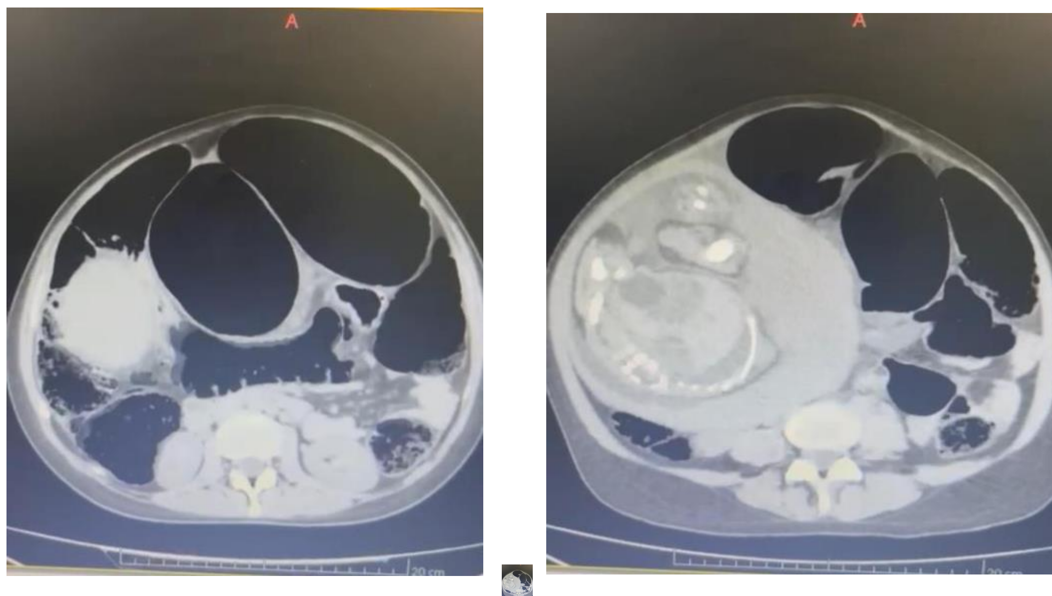

Figure 1-2. Abdominal CT, sigmoid volvulus

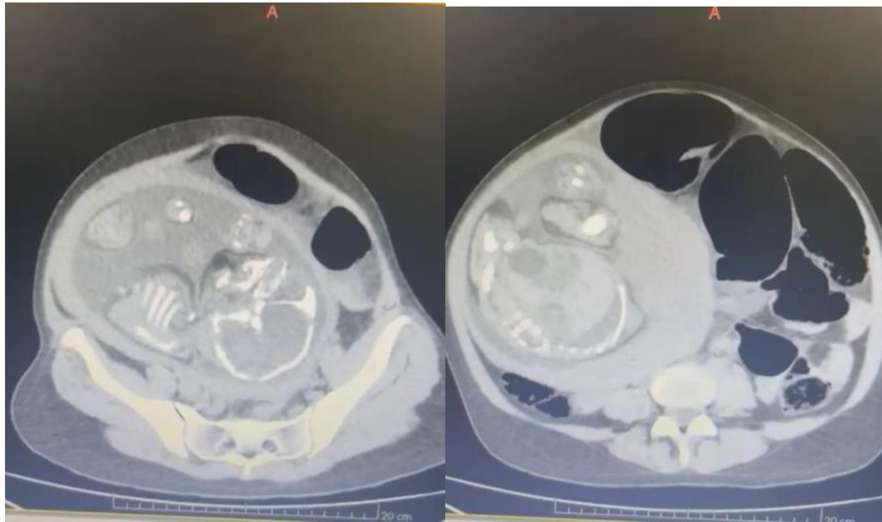

Figure 3-4. Pregnant uterus and intestinal obstruction

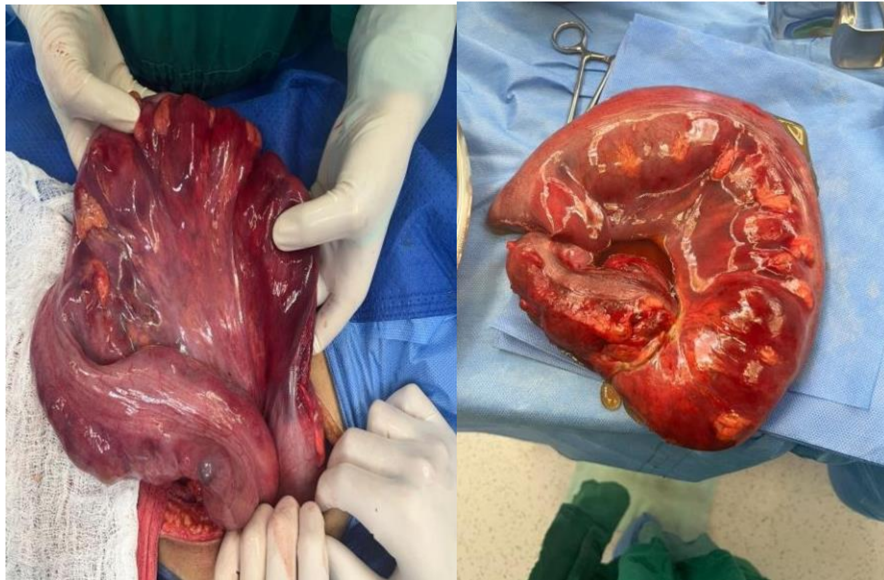

Figure 5-6. Sigmoid colon ischemia, resection and colostomy

CONCLUSION

Intestinal obstruction during pregnancy is very rare, which is why it is important to document the cases that exist during the medical career, all of this in order to evaluate each case individually, considering the use of more appropriate imaging methods and whether it ends or not. of pregnancy according to the gestational age of the patient.

It is difficult to diagnose considering several to differentiate between them, mainly acute appendicitis, abdominal peritonitis or acute cholecystitis.

Timely diagnosis through the use of computed tomography is important since the well-being of the mother and fetus at that moment and in the future depends on this.

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