**CASE REPORT**

**SIGMOID VOLVULUS COMPICATING PREGNANCY**

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**ABSTRACT**

Sigmoid volvulus complicating pregnancy is an extremely rare complication with fewer than 76 cases reported in literature. We report a case of sigmoid volvulus complicating pregnancy. The sigmoid colon was resected and Hartman’s colostomy was performed. The patient had a successful recovery. Aggressive resuscitation followed by early surgical intervention should be undertaken to reduce maternal and fetal morbidity and mortality.

**KEY WORDS:** pregnancy; volvulus

**INTRODUCTION**

Intestinal obstruction, complicating pregnancy is an extremely rare complication. Volvulus of sigmoid colon is the most common cause of intestinal obstruction complicating pregnancy, accounting for up to 44% of cases. Since the initial report by Braun in 1885, less than 76 cases [Table 1] have been reported in world literature. We present a case report of sigmoid volvulus complicating pregnancy to emphasize the typical clinical presentation of the condition, its progressive nature and deleterious effect on the foetus and the importance of early intervention.

**CASE REPORT**

Twenty-one-year old, primigravida, presented during 24 weeks of an otherwise uneventful pregnancy with complaints of intermittent abdominal pain and worsening constipation since 3 days. She had no history of previous medical problems or prior abdominal surgery. On physical examination, patient was febrile. Per abdominal examination revealed generalized abdominal tenderness and huge abdominal distention. Bowel sounds were absent. Fetal heart sounds were absent at presentation. Per rectal examination revealed an empty rectum with rectal ballooning. Pervaginal examination revealed a closed cervix. Abdominal radiography performed after admission suggested sigmoid volvulus. Doppler ultrasonography of the abdomen revealed a dead fetus. After initial resuscitation with IV fluids and nasogastric suction, the patient was taken emergently for exploratory laparotomy under general anesthesia. At laparotomy, an enormously distended sigmoid loop with gangrenous changes was found. The sigmoid colon was resected and Hartman’s colostomy was performed. Four hours postoperatively a dead male foetus was delivered following Syntocinon augmentation. The patient had an uneventful postoperative course thereafter and was discharged on a regular diet on postoperative day 10 after stitch removal.

**DISCUSSION**

Sigmoid volvulus should always be considered in a pregnant woman with intestinal obstruction. It is therefore especially important to be aware of this condition, which has a significant maternal and foetal mortality rate. Usually, nonspecific clinical diagnosis of intestinal obstruction is made and experience of this condition enabled the specific diagnosis in this case.

The pathogenesis may possibly be ascribed to an enlarging uterus pushing the long redundant sigmoid colon out of the pelvis, which then twists around its point of fixation on the pelvic sidewall.

Unfortunately, the pregnancy itself clouds the clinical picture because abdominal pain and leucocytosis are otherwise normal findings in pregnancy. In addition, hesitation in obtaining radiography contributes to delayed diagnosis.

The aim of management is to reduce the morbidity and mortality of both the mother and the fetus; however, this is frequently a challenging task. Aggressive resuscitation followed by early surgical intervention through a standard midline incision allows maximal exposure with minimal uterine manipulation. Nonviable bowel should be resected and diverting colostomy performed. Viable sigmoid should be derotated and deflated by sigmoidoscopic placement of rectal tube, and resection postponed to some point in the postpartum period. Conservative decompression via rectum is often unsuccessful as the large gravid uterus acts as a mechanical impediment to detorsion. Sigmoid volvulus complicating pregnancy has potentially devastating developments. As such, a high index of suspicion together with prompt intervention minimizes maternal and foetal morbidity and mortality.

**REFERENCES**


**Table 1: Reported case series of sigmoid volvulus with pregnancy**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Number of cases reviewed</th>
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<tbody>
<tr>
<td>Harer and Harer</td>
<td>Before 1958</td>
<td>52</td>
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<td>Lazaro et al.</td>
<td>1958-1969</td>
<td>13</td>
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<td>Keating and Jackson</td>
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<td>Lord et al.</td>
<td>1986-1996</td>
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<td>Joshi et al.</td>
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LETTER TO EDITOR

DERMATOLOGICAL SIDE EFFECTS OF OLANZAPINE

Sir,

Olanzapine has been recently introduced to India and is currently one of the most commonly prescribed antipsychotic medicines. Although relatively safe as compared to other antipsychotic medications, few reports have suggested debilitating side effects of olanzapine. Although dermatological side effects are uncommon with antipsychotic medicines, two recent reports have described skin rashes and eruptions with olanzapine.[1],[2] We describe a purpuric skin rash associated with olanzapine and a brief review of literature is also provided.

A 23-year-old man presented to us with history of recent heavy use of cannabis, which was followed by grandiose ideations, increased activity, decreased sleep, and increased self-esteem. A diagnosis of substance-induced mood disorder (DSM IV) was made and the patient was started on 15 mg of olanzapine. After 2 days of initiation of treatment, the patient was noted to have numerous purpuric spots over his face and trunk. These blanching nonpruritic purpura were not associated with any fever or any other signs of urticaria. The purpura extended to cover most of his trunk and face the following day, after which the dose of olanzapine was reduced to 5 mg/day and a mood stabilizer was planned. After the dose reduction, there was a mild reduction in the signs, but the purpura persisted. Because the manic symptoms were becoming difficult to control after a few days the olanzapine was increased to the previous dose. The purpuric rashes reappeared in a similar pattern over his trunk and face. The medicine was changed to Haloperidol 10 mg/day after which the rashes resolved spontaneously over the next few days. The patient was not on any other medication. There was no eosinophilia, or thrombocytopenia, and the liver function tests were within normal limits. Skin biopsy could not be done owing to the manic symptoms and uncooperative nature of the patient.

The adverse drug reaction probability score for the patient was ten, denoting a definite role of olanzapine in the occurrence of the rash.[3] Hypersensitive reaction with fever and hepatitis has been reported with olanzapine.[1] Other dermatological side effects that have been reported with olanzapine are eruptive xanthomas,[2] skin hyperpigmentation,[4] and purpura associated with thrombocytopenia. Congeners of olanzapine such as clozapine has been reported to have numerous dermatological side effects that are immune mediated. Very few reports are available about the dermatological side effects of olanzapine. Physicians should be aware of the various dermatological side effects of olanzapine.

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REFERENCES