Acute diverticulitis in a patient with intestinal malrotation

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Clinical case

61 year-old female, afebrile and hemodynamically stable, admitted to emergency room reporting abdominal pain of 5 days duration. Abdominal examination: soft and depressible abdomen, painful on palpation at left iliac fossa, without defense. TAC: multiple diverticula in the descending colon and sigmoid, thickened wall and discrete pericolic fat inflammatory changes (Figure 1), ansae of the small intestine in right iliac fossa (RIF) (Figure 2), in maximum intensity projection (MIP), intersection of the superior mesenteric artery in front of the vein, at the right of it (Figure 3).

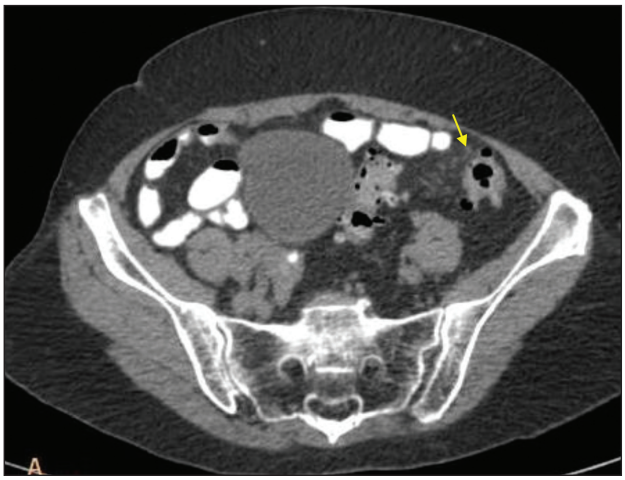

Figure 1 – Multiple diverticula in the descending colon and sigmoid with a colon segment showing thickened wall and discrete pericolic fat inflammatory changes.

Discussion

Intestinal malrotation in adults has an approximate incidence of 0.19%[1]. It can have an acute presentation (intestinal obstruction, volvulus, intestinal ischemia) or a chronic one, with crampy abdominal pain and bilious vomiting. Sometimes patients are asymptomatic, being an incidental discovery to find it on radiological explorations due to other reasons, as in the case presented here. All symptomatic patients should be treated surgically, by the Prophylactic

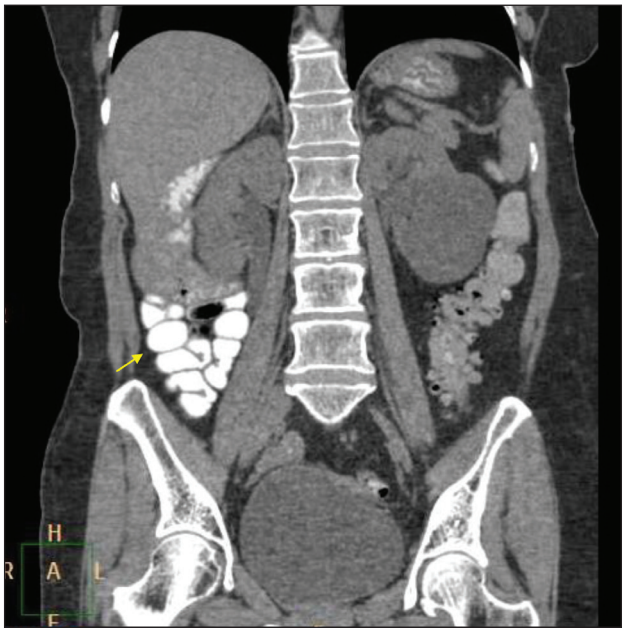

Figure 2 – Ansae of small intestine in RIF (right iliac fossa).

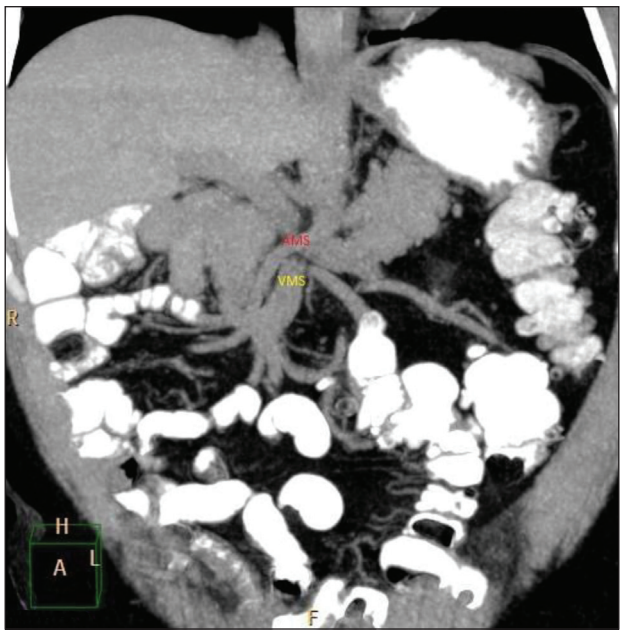

Figure 3 – Intersection of the superior mesenteric artery in front of the vein, at the right of it.

Ladd Procedure. Our patient had no previous abdominal symptoms due to the intestinal malrotation. In asymptomatic adults this procedure is uncertain due to the low incidence of small intestine volvulus in these patients[2,3].

References

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