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Jejunal Diverticular Perforation: About A Case from Ignace Deen's Department of General Surgery

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ABSTRACT

Introduction: *The objective was to report a rare case of the surgical discovery of a perforated jejunal diverticulum.*

Observation: *A 68-year-old woman consulted for abdominal pain of 3 days duration accompanied by transit disorder. The abdominal pain was located on the left flank and was accompanied by vomiting. The patient had taken decoctions without favorable results. The persistence of the pain and vomiting motivated the consultation. Her general condition was impaired. The abdomen was distended and tender. The prehepatic dullness was preserved. Peristalsis was audible, and the hernial orifices were free. The X-ray showed hydro-aeric levels and aerocoly with pneumoperitoneum. The laparotomy documented a moderate amount of serohematic fluid accumulation and a perforated jejunal diverticulitis. A jejunal resection was performed removing the diverticulum and the postoperative course was good.*

Conclusion: *The perforation of the jejunal diverticulum is a rare and serious complication, often discovered during surgery and likely to compromise vital prognosis.*

Keywords
Jejunal diverticulum, Perforation, Surgery.

Introduction
Jejunal diverticulum is a silent condition, discovered late, which can be complicated by perforation. This serious complication of diverticulitis often requires emergency surgery. The intraoperative discovery of a perforated jejunal diverticulum is a rare situation that deserves to be shared.

The objective was to report this rare case discovered during surgery.

Case Report
It's about a 68-year-old housewife living in Conakry presented with abdominal pain for 3 days, accompanied by vomiting and altered bowel habits.

The onset of the illness was sudden, marked by abdominal pain in the left flank, of increasing intensity, accompanied by nausea and vomiting. The patient reportedly took decoctions without any positive results. The persistence of the pain and vomiting prompted the consultation.

She has a history of functional irritable bowel syndrome. Her general condition was characterized by anorexia, physical asthenia, and weight loss. Pallor of the conjunctiva and skin was noted. Blood pressure was 120/70 mmHg, pulse 88/min, and temperature 38.7°C. The abdomen was distended, symmetrical, and tender. Prehepatic dullness was preserved. Peristalsis was audible, and the hernial orifices were free. Gastrointestinal and gastrointestinal examinations were unremarkable. Abdominal ultrasound showed intestinal distension, attributed to irritable bowel syndrome. PSA showed fluid levels and aeroileus, but no pneumoperitoneum.

The patient received medical treatment with no positive results. Given persistent pain and impaired bowel function, an exploratory laparotomy was performed. Laparotomy revealed moderate

abundance of serohematic fluid, a jejunal diverticulum with infiltrated and perforated wall, and an obstructed intestinal lumen.

Figure 1: Jejunal diverticulum and serohematic effusion.

We collected the fluid for cytology and resected the diverticulum, then performed the jejunojejunal anastomosis. The surgical specimen was sent to the pathology department. The patient was discharged from the hospital on the 8th postoperative day.

The postoperative course was uneventful.
Histology revealed no signs of malignancy.

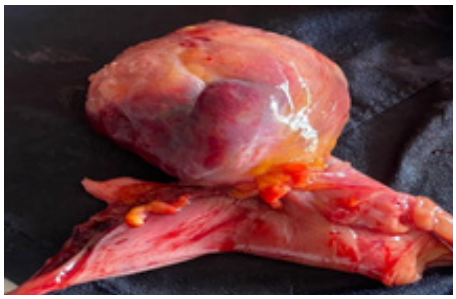

Figure 2: The surgical specimen was sent for histology.

Discussion

Jejunal diverticula are rare, with a prevalence ranging from 0.06% to 4.6%. They remain asymptomatic in most cases. Their etiology is still poorly understood, and their symptoms are nonspecific. This condition develops in areas of weakness in the jejunal wall corresponding to sites of blood vessel penetration. A motility disorder is suspected to be responsible for the formation of an asymptomatic diverticulum because it remains asymptomatic for a long time. Chronic abdominal pain accounts for 40% of clinical presentations [1,2]. This pain reflects diverticulitis, the main complications of which are perforation followed by obstruction and hemorrhage [3,4].

In our case, peritoneal syndrome was suspected, and pneumoperitoneum suggested perforation. Imaging, such as computed tomography (CT), can demonstrate intestinal injury and thickening or infiltration of the intestinal wall [4]. Diverticulitis was discovered only at laparotomy. The diverticulum was inflamed, perforated, and the intestinal lumen was obstructed. Asymptomatic jejunal diverticulosis does not require surgical management unless there are complications or symptoms [5,6].

The authors reported a case revealed by computed tomography (CT) with jejunal thickening and numerous saccular addition images interpreted as diverticulitis [7].

Perforation with generalized peritonitis requires surgical intervention such as laparotomy with segmental resection of the small intestine and primary anastomosis [8]. Our patient underwent surgery, and the surgical procedure consisted of jejunal resection followed by jejunojejunal anastomosis. The postoperative course was uneventful.

Conclusion

Jejunal diverticulitis is rare and often discovered late. Treatment for complicated perforations is surgical. The prognosis depends on the time to consultation and the associated lesions.

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