



LETTER TO THE EDITOR

Subacute bowel obstruction secondary to idiopathic adhesions in a patient without previous intra-abdominal surgery[☆]



Suboclusión intestinal secundaria a adherencias idiopáticas en paciente sin cirugía intraabdominal previa

Dear Editor,

We read with great interest the article by Martín-Lagos Maldonado A et al.¹ describing pelvic inflammatory disease as an uncommon cause of bowel obstruction due to adhesions. We would like to report another uncommon case of bowel obstruction due to adhesions, in this case due to adhesions of idiopathic origin.

Intra-abdominal adhesions may be congenital or acquired.² In cases in which no cause can be identified, they are considered to be of idiopathic origin.³ Given that idiopathic adhesions are uncommon since the adhesion cause is generally diagnosed, we report the case of a patient with intestinal subocclusion due to idiopathic adhesions.

A 65-year-old man with no history of abdominal surgery visited the emergency department due to abdominal pain. He did have a history of scoliosis. The patient reported diffuse abdominal pain and vomiting lasting 24 h, with difficulty breaking wind and defecating. It was the third episode in the past year. On examination, he presented a distended abdomen with diffuse pain and no signs of peritoneal irritation. Laboratory testing revealed a leukocyte count of 17,600 and a C-reactive protein (CRP) level of 6.7 mg/dl. An abdominal X-ray and a computed tomography scan showed air-fluid levels in the small intestine, but did not show the cause of the patient's signs and symptoms of subocclusion. After clinical improvement was not achieved with conservative treatment, an exploratory laparotomy was performed. This yielded the sole finding of multiple firm adhesions in a segment of middle jejunum measuring 50–60 cm, resulting in several bends interfering with bowel transit (Fig. 1A). The rest of the abdominal cavity was normal. A bowel resection including the affected bowel loop (Fig. 1B) and a mechanical laterolateral isoperistaltic anastomosis were performed.

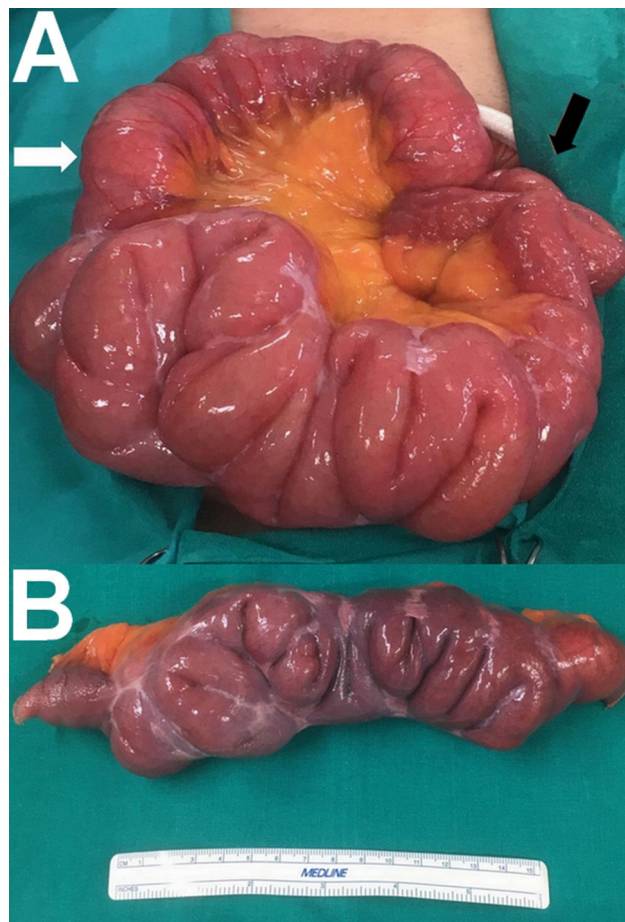


Figure 1 A. Segment of middle jejunum measuring 50–60 cm with multiple firm adhesions resulting in several bends interfering with bowel transit. The afferent loop (white arrow) and the efferent loop (black arrow) are visible. B. Bowel resection specimen from the affected segment showing multiple fibrous adhesions resulting in several bends.

The histopathology analysis showed only fibrous adhesions and ruled out other underlying causes. After a year of follow-up, the patient was asymptomatic.

Postoperative acquired intra-abdominal adhesions are the most common type of adhesion (accounting for 90% of all adhesions).⁴ They form in 50%–100% of patients who undergo abdominal and pelvic surgery,² especially in those having undergone a laparotomy.⁴ Fortunately, the incidence of adhesions has decreased considerably in the era of laparoscopic surgery.⁴

In the absence of prior abdominal surgery, acquired adhesions may be due to inflammatory causes, infectious causes

[☆] Please cite this article as: Ruiz Pardo J, García Marín A, Ruescas García FJ, Valiente Carrillo J. Suboclusión intestinal secundaria a adherencias idiopáticas en paciente sin cirugía intraabdominal previa. Gastroenterol Hepatol. 2020;43:481–482.

or radiotherapy sequelae. Notable inflammatory-infectious aetiologies reported include endometriosis and pelvic inflammatory disease in women,^{1,4} diverticular disease (especially of the small intestine), Crohn's disease, and abdominal tuberculosis in endemic areas. Abdominal and pelvic radiotherapy in the treatment of gynaecological, prostatic, rectal and lymphoproliferative neoplasms may also cause adhesions. Their severity depends on the extent of the treated area, the degree of fractionation of the dose, and the total dose of radiation.⁴ In addition, post-inflammatory adhesions have been detected on autopsy in up to 28% of cases of patients with no history of abdominal surgery.² In the case reported, a colonoscopy and a gastroscopy were performed to rule out inflammatory bowel disease. A tuberculin test was also done to rule out prior exposure to the tuberculosis bacillus. The results were negative. All other causes were ruled out given the patient's sex and personal history and the histopathology examination of the resected bowel.

Congenital adhesions form during embryonic development,² and are an extremely uncommon cause of bowel obstruction in adults.⁵ They are most often located between the terminal ileum or its mesentery and the ascending colon, ligament of Treitz, right liver lobe or bladder. In most cases, they consist of connective tissue containing vessels and nerves.⁵ In the case reported, a congenital aetiology was ruled out in light of the patient's age and because he had multiple adhesions that contained neither blood vessels nor nerves and were not located in the typical locations described above.

With all acquired and congenital aetiologies having been ruled out, the patient's adhesions were deemed to be of idiopathic origin. In conclusion, idiopathic adhesions should be borne in mind in the differential diagnosis of bowel obstruction in patients with no prior abdominal surgery, especially where radiological testing does not show any responsible lesion.

Conflicts of interest

We declare that there are no matters in relation to funding or of any other nature that might create any conflict of interest.

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Endoscopy activity in a covid-19 high-risk area (Barcelona): Moving forward (or backwards) according to the necessary resources available



Reinicio de la actividad endoscópica en un área de alto riesgo de covid-19 (Barcelona): progresión (o regresión) según los recursos necesarios disponibles endoscopy

Dear Editor:

Endoscopy activity has been dramatically reduced to minimum due to COVID-19 outbreak consequences. Endoscopy Units are experiencing shortages in staff, personal protective equipment (PPE), medical equipment as respiratory ventilators and monitors, beds or even physical space. Moreover, cleaning rooms have gained a new role of PPE (i.e. goggles, or face shield) disinfection from different hospital

areas. For this reason, it is convenient to be prepared on how to resume non-urgent and non-delayable endoscopy activity and adapt to the natural evolution of pandemic.

We recommend to progress to an adapted activity in a three-phase system.

For that, some minimum requirements are necessary to move forward on endoscopy activity, grouped in 3 basic needs: Workforce trained in endoscopic procedures, PPE availability and testing capacity for COVID-19 [Fig. 1]. The movement between the phases could be bidirectional depending on pandemic situation. So, the phases will be dynamic returning to a previous phase or progressing to an advanced phase.

With only one team available in the unit, it will be very risky planning to do semi-urgent endoscopy on a regular basis, considering the quarantine likelihood if health care workers get infected. On the other hand, to start assuming more schedule of procedures, it is necessary to expand the number of rooms depending on the capacity of the endoscopy unit. This may imply bringing personnel back from COVID-19 tasks.