ER-GS Combined Meeting

報告者：PGY 宋明璋
指導者：連楚明 副主任
990915

Basic data

- Name: 何X X
- Gender: female
- Age: 47 year-old
- ID number: 166-----
- Date of coming ER: 99/8/28, AM01:02
- 入院方式: 推車
- 痛苦指數: 10
- Triage: 2
- Vital signs: BT: 36℃, pulse: 79/min,

Chief complaint

- Abdominal pain for several days

Present illness

- This 47 year-old women with the history of HTN and peptic ulcer visited ER, because of abdominal pain for several days. She suffered from **sudden onset of abdominal pain** since a few days ago. The pain was **dull** and **intermittent**.
- Nausea, vomiting, cold sweating, abdominal fullness and no bowel movement were also noticed.

Present illness

- She had similar symptoms for years. However, the symptoms attacked more often recently. There was no fever, diarrhea or tarry stool.
- Besides, she also complained of dysmenorrhea and hypermenorrhea.

Past history

- Hypertension
- Peptic ulcer
- Operation history: nil

Personal history

- Allergy: no known agent
- Smoke: nil
- Alcohol: nil
- Betel-nut: nil

Family history

- Non-contributory

Physical examine

- Consciousness: alert, GCS: E4V5M6
- HEENT: conjunctiva: pale, sclera: anicterus
- Neck: supple, no jugular vein engorgement, no lymphadenopathy
- Chest: smooth breath pattern, clear breath sound, regular heart beats
- Abdomen: soft and distend, no guard
  hypoactive bowel sound
  RLQ tenderness with mild localized rebound tenderness

Lab data

- **CBC/DC**:

WBC: 13500 RBC: 4.96 Hb: 9.6
MCV: 66.1 MCH: 19.4 RDW: 24.7
PLT: 748000
Seg: 75.9% lymph: 16% Mono: 6.8%
Eosin: 1.0%

- 生化:

Glucose: 113 AST: 19 BUN: 8
Creatinine: 0.5 Na: 137 K: 3.8
GFR: 132.25 lipase: 18 CRP: 0.294
LDH: 193

Lab data

- **U/A**:

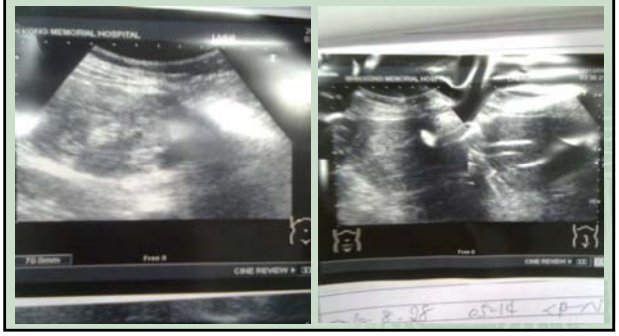
RBC: 1-2/HPF WBC: 1-2/HPF
Epi cell: 0.1/HPF bacteria: +/-
Crystal: not found cast: not found
Pregnancy EIA: negative

- **ABG**:

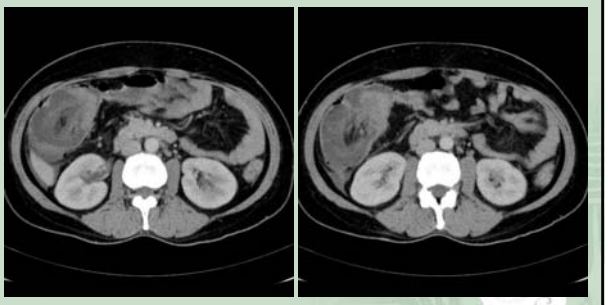
PH= 7.47 PCO2= 30.2 mmHg
PO2= 65 mmHg HCO3= 22.1 mmol/L
BE= -2 mmol/L TCO2= 23 mmol/L
SO2= 94%

Bedside echo

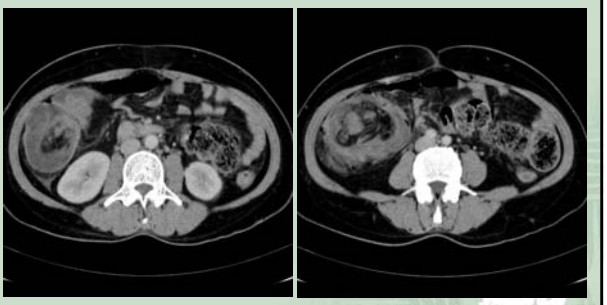
- Huge A-colon mass



Abdomen CT



Abdomen CT



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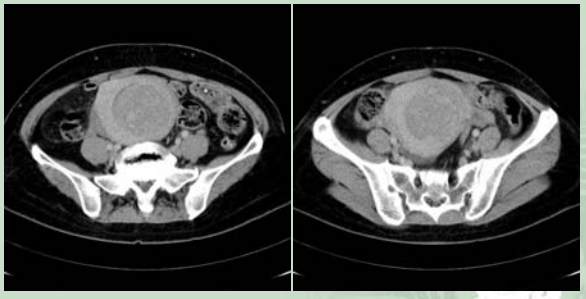
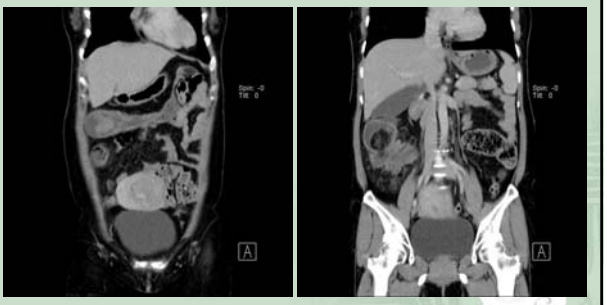
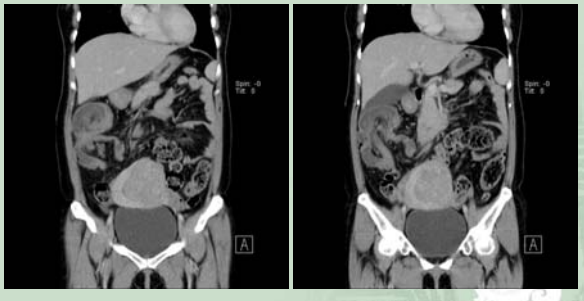


Abdomen CT



Abdomen CT



Abdomen CT report

1. Huge A-colon tumor with intususception, ileo-colic type
2. Uterine myoma about 6.6 cm

Management

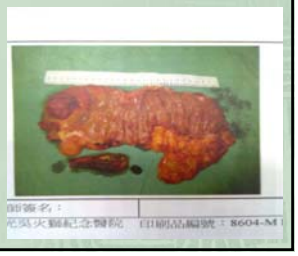
1. Morphine for pain control
2. Empiric antibiotics: Cefmetazole 1g q8h
3. Consult GS

OP procedure

1. Right hemicolectomy
2. Cholecystectomy
3. Total hysterectomy, TAH

OP finding

1. 4*4*2 cm cecal tumor, soft polypoid
2. 1.8 cm GB stone
3. Straw color ascites



Pathology

1. INTESTINE, LARGE, CECUM
   — TUBULOVILLOUS ADENOMA WITH FOCAL MALIGNANT CHANGE
   — RESECTION MARGIN FREE
2. ASCITES: NEGATIVE FOR MALIGNANCY

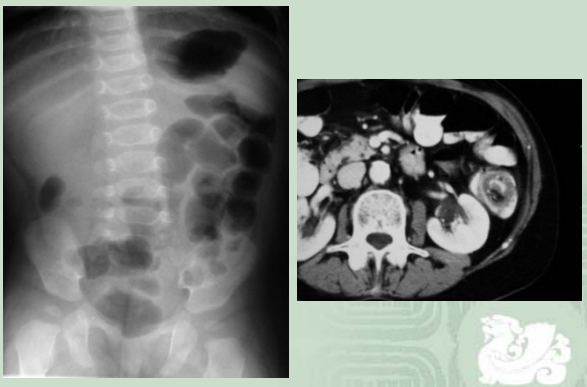
Discussion

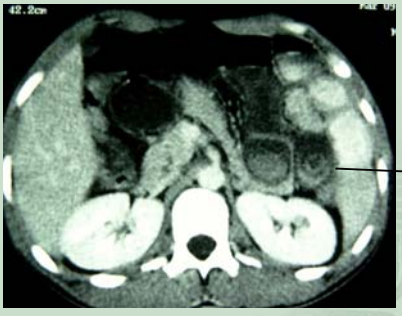
Intusussception

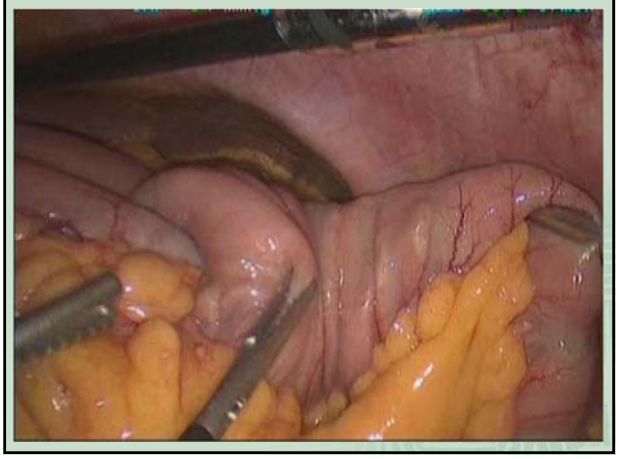
- Cause:
  - a segment of intestine invaginates into the adjoining intestinal lumen
  - an imbalance in the longitudinal forces along the intestinal wall
  - a lead point or by a disorganized pattern of peristalsis

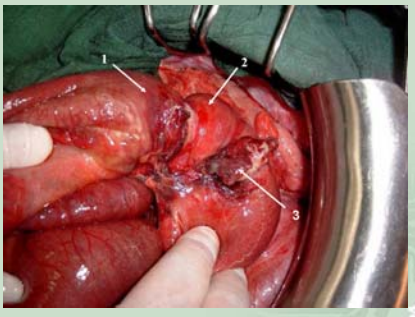
Intususception

- common in children
- much less common in adults
- < 5% of cases of mechanical small bowel obstruction









1- intussusceptum; 2- intussuscipiens; 3- Meckel's diverticulum

Lead point

- Meckel diverticulum
- Enlarged mesenteric **lymph node**
- Benign or malignant **tumors** of the mesentery or intestine
- Mesenteric or duplication **cysts**
- Submucosal **hematomas**
- Ectopic pancreatic and gastric rests
- Inverted appendiceal stumps
- Sutures and staples along an **anastomosis**
- Intestinal **hematomas**

Triad of symptoms

- intermittent colicky abdominal pain (71%)
- bilious vomiting (68%)
- abdominal distention (45%)
- "currant jelly" stool (child)

↓

intestinal obstruction

Diagnosis

- KUB
- Ultrasound
- CT

Treatment

- All adult patients with intussusception require laparotomy.
- Resection is indicated in cases of large bowel intussusception.
- Reduction without resection may be an option in cases of small bowel involvement where the incidence of malignancy is not great and no abnormality of the small intestine is observed.

Small bowel obstruction

- The most common causes:

1. Adhesion
2. Bulge = hernia
3. Cancer and tumors

Small bowel obstruction

"Gives bad cramps"

G: gall stone ileus	D: diverticulum
I: intususception	C: crohn's disease
V: volvulus	R: radiation enteritis
E: external compression	A: annular pancreas
S: SMA syndrome	M: Meckel's diverticulum
B: bezoar; bulge(hernia)	P: peritoneal adhesion
A: abscess	S: stricture

Proximal obstruction

- Profuse vimiting
- Seldom feculent
- Variable pain, usually described as abdominal discomfort not cramping pain

Middle/distal obstruction

- Typical cramping pain
  - In paroxysms at 4- to 5- minute
  - Crescendo – decrescendo pattern
- Poorly localized abdominal pain
- More distal, more feculent vomiting

Strangulation or peritonitis

- Pain pattern change
  - Intermittent cramping pain → continuous severe abdominal pain
- Fever, tachycardia, localized tenderness, muscle guarding
- Rectal exam showed blood

The End

Thanks a lot