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MASSIVE RECTORRHAGIA IN A RURAL HOSPITAL IN KENYA.
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SUMMARY

A young female patient presented to our hospital for massive rectorrhagia associated with clinical signs of peritonitis. The provisional diagnosis was of sigmoid volvolus, but laparatomy demonstrated that the problem originated from Pelvic Inflammatory Disease (PID). Despite prompt and uncomplicated surgery the patient did not survive, probably because of septicaemia or pulmonary embolism.

INTRODUCTION

Acute abdomen of gynaecological origin is very common in rural setting in Kenya (1).

Quite often patients may present too late, when even an emergency surgical procedure cannot help. Gynaecological peritonitis can present with unusual features, therefore causing delay in diagnosis and treatment.

CASE REPORT

An 18 years old female patient was admitted to our hospital for massive rectorrhagia and with acute abdomen. The patient was passing fresh blood and clots from her anus, without any stool. The differential diagnosis included complicated Shistosomiasis (2) (Shistosoma Mansoni is prevalent in Tharaka area – where the patient came from); the abdomen of the young lady was clearly peritonitic with a large mass below the umbilicus. The intestinal murmur was absent, and apart from blood, she had not passed stool for the last three days.

The general conditions were poor with an Hb level of 4 g/dL. As a first step of treatment we decided to haemodynamically stabilise the patient with IV fluids and blood transfusion.

A U/S (Ultrasound) in emergency showed an ambiguous picture, without presence of free fluid in the abdominal cavity, but with dilated and immobile loops of intestines.

Therefore, we decided to perform a digital rectal examination: the examining finger reached a kind of obstructive wall at about 5 cm from the anus. It was not a mass; but rather an edematous mucosa. The two findings together supported a potential diagnosis of sigmoid volvolus. Therefore it was decided to perform an emergency laparatomy.

The patient was intubated and given general anaesthesia with relaxation. Once the abdominal cavity was opened, the surgical team found a situation much worse than expected: in fact a very thick omentum was covering a completely coiled intestine. The adhesions involved the whole of the gut from duodenum up to the rectum. The surgeons started a difficult and lengthy job of adhesion release. The procedure was quite complicated around the sigmoid and the colon, while rather simple at the level of the small intestine. They did not find any intestinal perforation although the appendix was covered with fibrin and they decided to remove it. In the Douglas pouch there was plenty of pus and necrotic debris, probably imprisoned there by the omentum: the material collected was foul smelling, probably dating quite old. The uterus was looking nearly necrotic and bluish in colour. Both tubes were enlarged and bumpy like in pyosalpinix and their appearance was similar to the uterus.

We therefore concluded that the patient got a pelvi-peritonitis secondary to PID (Pelvic Inflammatory Disease). The peritonitis had later diffused and extended, causing progressive coiling of the intestinal loops, ending up in a condition of capillary stasis and break-down, responsible of the rectorrhagia.

Although surgery was performed without any major technical issues, the young
patient died unexpectedly few hours afterwards.

DISCUSSION

The situation proved extremely frustrating and disappointing, as, in spite of what we believe it was an evidence-driven correct diagnosis which supported the decision on emergency operation, the young patient died soon after the surgery.

A possible explanation is that the peritonitis had been lasting for too long, before the patient came too late to our observation and was admitted for emergency procedure – this delay most likely allowed

the peritonitis to favour a septicaemia. Alternatively, it may have been an embolism triggered by the surgical procedure itself. Since an autopsy was not performed, we cannot exclude the latter which remains a possible complication of major surgical
procedures especially in similar cases.

In conclusion, this report aims at sharing about the very common and often lethal event of acute abdomen of gynaecological reasons in rural Kenya. Awareness of medical staff and nurses even in rural facilities and education of people to recognise early symptoms may favour earlier presentation to hospital and therefore better outcome of patients if surgery is performed by trained staff before peritonitis develops into septicaemia. In addition preventive and timely use of broad spectrum antibiotics in referred patients may reduce the risk of septicaemia.

REFERENCES

1. Wamwana EB, Ndavi PM, Gichangi PB, Karanja JG, Muia EG, Jaldesa GW. Socio-demographic characteristics of patients admitted with gynaecological emergency conditions at the provincial general hospital, Kakamega, Kenya. *East Afr Med J*. 2006 Dec;**83**(12):659-65.
2. Ogutu EO, Wankya BM, Shah MV, Ndinya-Achola JO. Prevalence of spontaneous bacterial peritonitis at Kenyatta National Hospital. *East Afr Med J*. 1988 Aug;**65**(8):547-51.
3. Mazigo HD, Giiti GC, Zinga M, Heukelbach J, Rambau P. Schistosomal peritonitis secondary to perforated appendicitis. *Braz J Infect Dis*. 2010 Nov-Dec;**14**(6):628-30