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Jejunal Diverticulosis: Resect Or Not To Resect?

Chen Ah Moon, Khoo Kah Seng, Mohamed Rezal Bin Abdul Aziz

University Malaya Medical Centre, Kuala Lumpur, Malaysia

Introduction

Jejunal diverticulosis is a rare entity of about 0.3-2.3%. Patients usually asymptomatic and discovered incidentally <3% in autopsy and <5% in imaging [1]. It is more common in men and incidence increases with age, highest prevalence at 60-70 [2]. Patients may present with diverticulitis, perforation, bleeding or obstruction. To date, there is no consensus on the management of small bowel diverticulitis.

Case Report

We report a case of 48 year-old male with underlying gout. He presented with sudden onset of severe left sided abdominal pain for 3 days associated with fever. Clinically tenderness over left lumbar with localised guarding. Blood investigations showed raised septic parameters and acute kidney injury. X-ray was unremarkable. Contrast enhanced computed tomography (CECT) abdomen pelvis showed diverticulum at duodenum, jejunum, right and left colons. Extensive fat stranding at left lower abdomen adjacent to ileum with air locule, no collection.

He was initially treated conservatively with antibiotics and hydration. Patient remained septic despite 24 hours of antibiotics with persistent abdominal pain. Hence, we decided for laparotomy. Intra-op noted multiple jejunal diverticula from 10cm-50cm from duodeno-jejunal (DJ) junction with clump of small bowel with thickened and slough along mesentery border of jejunum about 60-80cm from DJ. No collection and air leak test negative, hence no bowel resection was done. He was discharged well at day 7 post surgery, and remained well during review 1 month later.

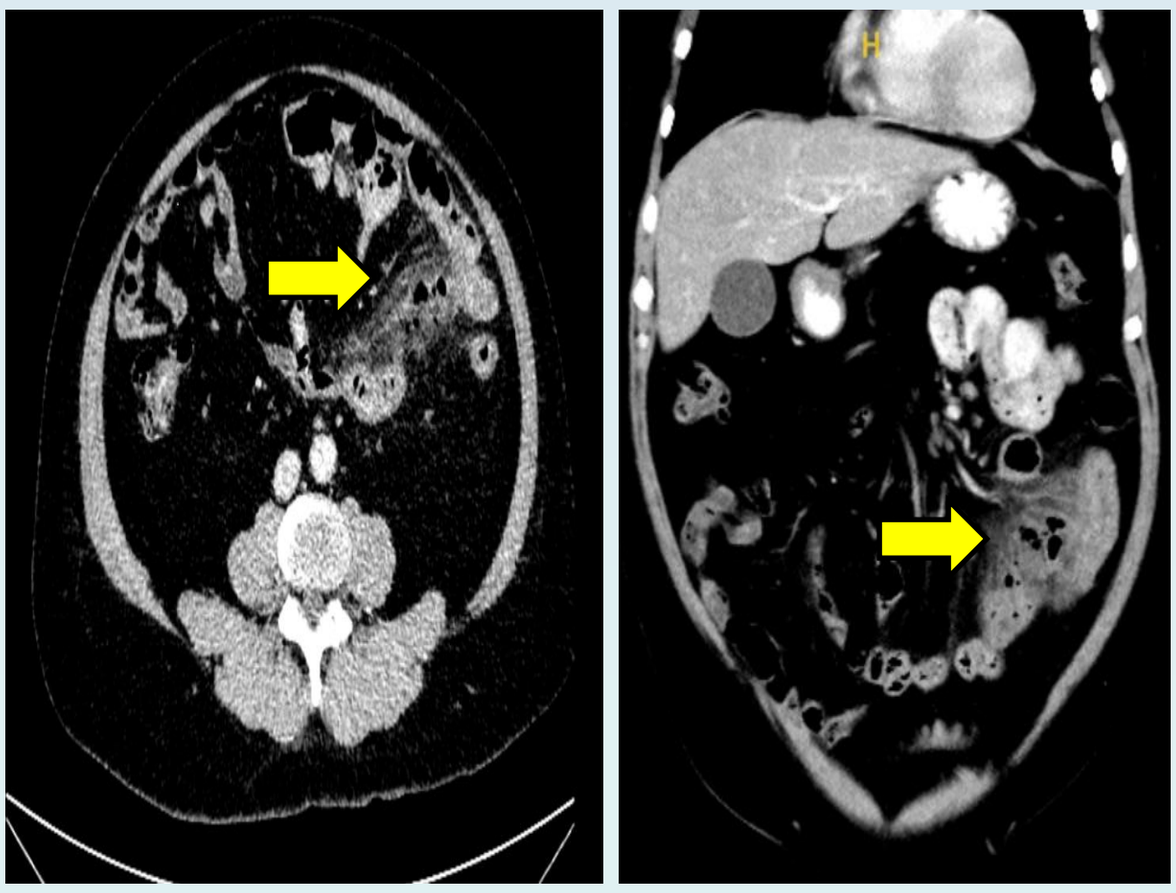

Figure 1: CECT abdomen pelvis showed mesentery streakiness with thickening and air locules along small bowels (left: axial view, right: coronal view).

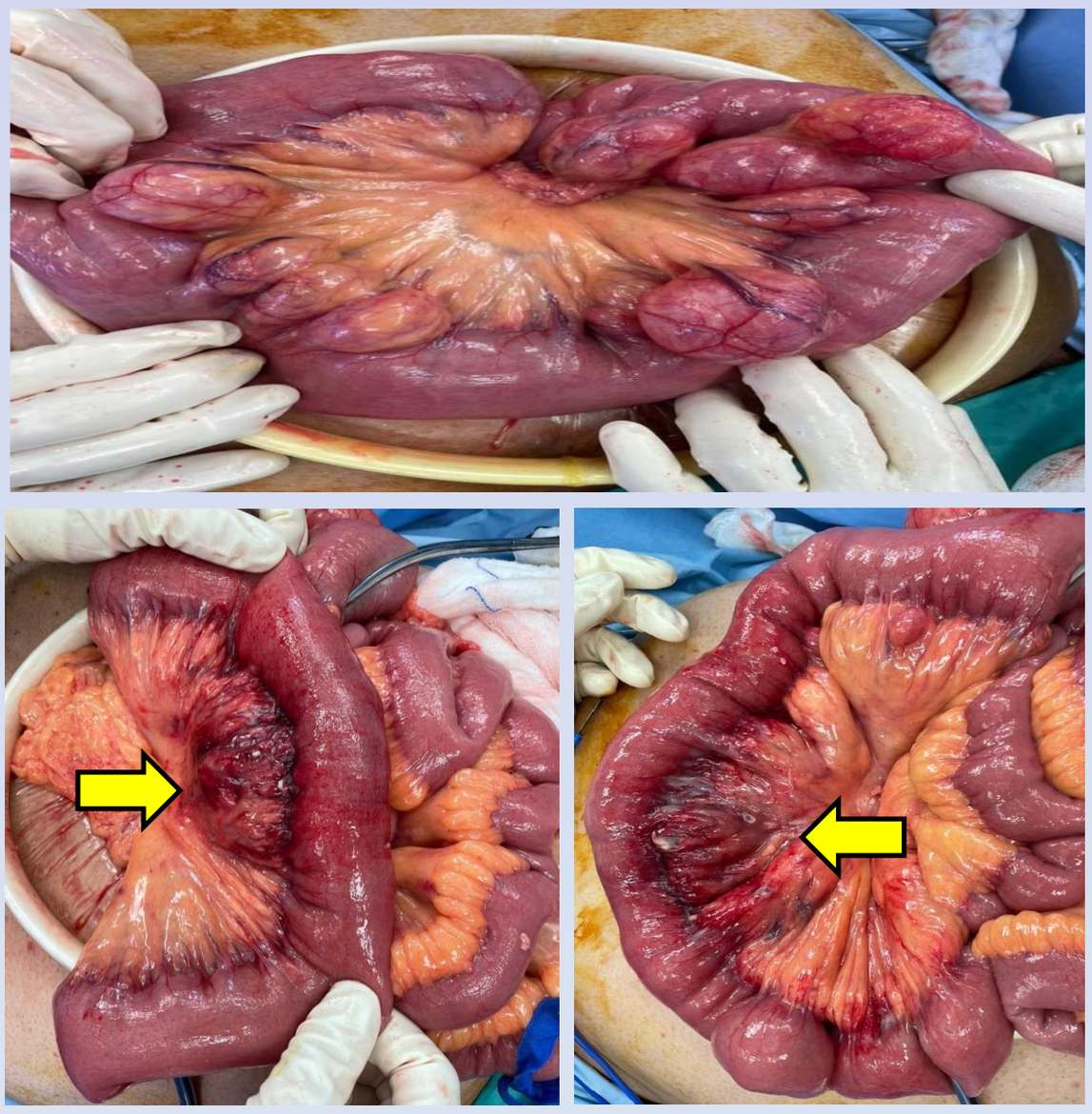

Figure 2: Multiple jejunal diverticula 10-50cm from DJ (above). Thickened, inflamed and slough along jejunal mesentery 60-80cm from DJ (below).

Discussion

Jejunoileal diverticula are usually multiple and localized to proximal jejunum. This disease remains to be a challenging as symptoms are vague and non-specific. The gold standard modality of imaging is CT scan showing outpouchings of intestinal wall which may contain air, contrast or collection. There is no best practice guideline due to rarity of the disease. The management of small bowel diverticulum can be medical or surgical treatment depend on clinical condition and the presence of complications at the time of presentation [3]. In case of nonperforated localised peritonitis, trial of medical treatment with broad spectrum antibiotics. Image guided percutaneous drainage for localised collection before invasive surgical intervention [4]. Urgent surgical intervention of either laparoscopic or laparotomy with segmental bowel resection is mandatory if failed medical treatment or generalised peritonitis. Serial examination and close observation is important if patient on conservative treatment.

Conclusion

Jejunal diverticulosis is a rare disease and dilemma to resect or not during surgery in a non-perforated case can be challenging. Individual approach management should be tailor after taking into patient's and disease factors.

References

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