Poster No. 2803

Caecal Bascule: Unraveling The Twist!

Joel A[1], Tharveen N[1], Mathew T[1]

[1] *Department of General Surgery, Hospital Sultan Ismail, Johor, Malaysia*

Introduction

- Caecal bascule, marked by abnormal cecal folding or displacement, poses a risk of bowel obstruction. Unlike caecal volvulus, it entails a distinctive cecal folding or tilting, necessitating urgent surgical intervention.

Case Report

- We present the case of a 65-year-old Malay lady, with a history of multiple caesarean sections and a recent left neck of femur fracture. Her symptoms indicated intestinal obstruction, confirmed by a supine abdominal X-ray (Figure 1) showing dilated bowels. CT Abdomen revealed a dilated caecum with abnormal orientation, prompting suspicion of caecal bascule (Figure 2 A and B). An emergency laparotomy, caecopexy, bowel decompression, and appendicectomy were performed. Postoperatively, she experienced ileus, which resolved, leading to her discharge on day 9 post-op.

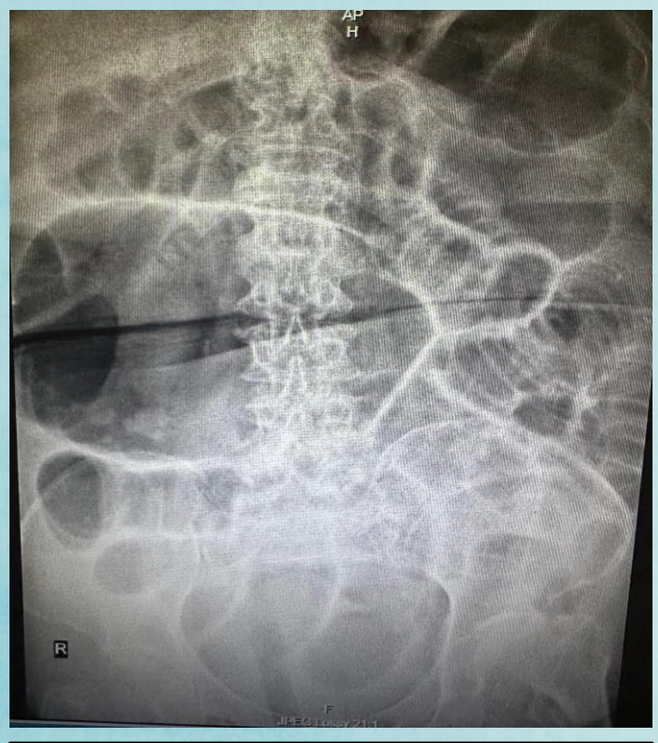

Figure 1: Dilated segment of large bowel

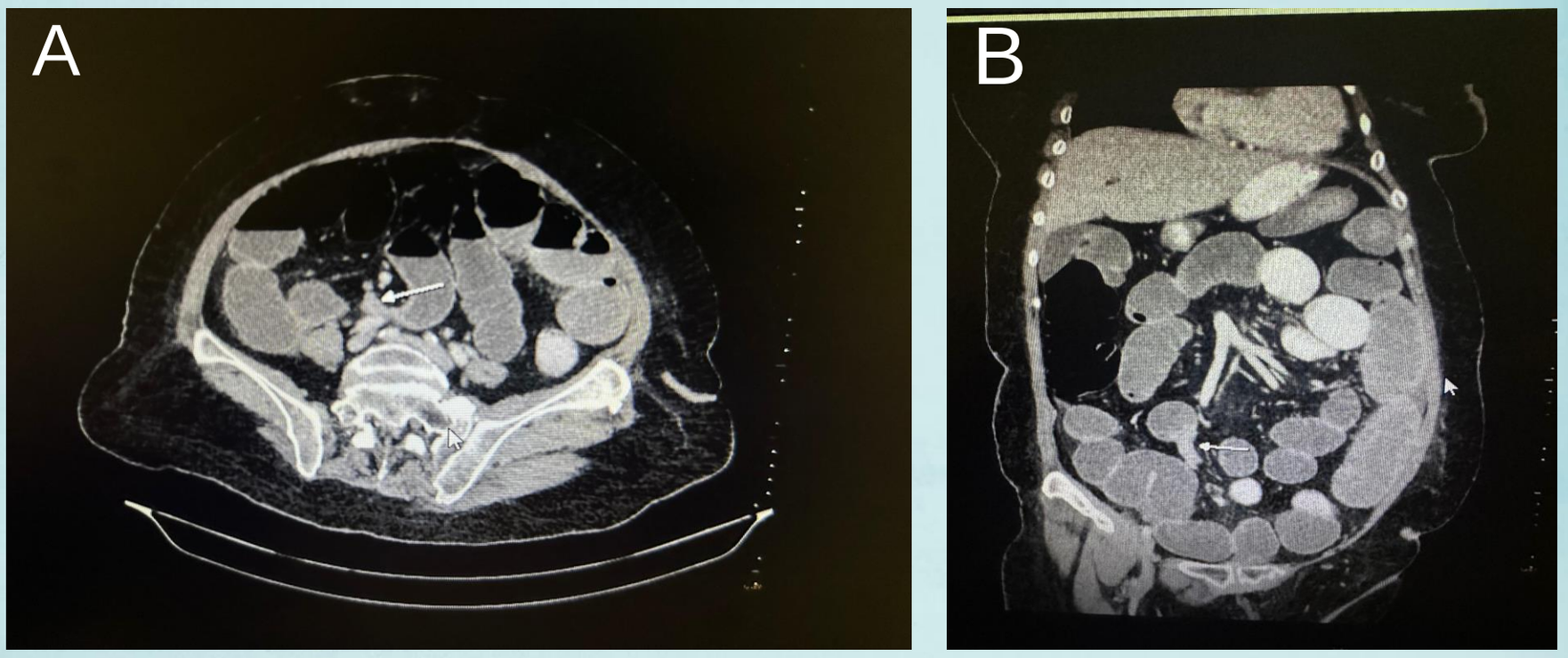

Figure 2 (A and B) CT scan images of the Caecal Bascule

Discussion and Conclusion

- Caecal bascule, characterized by the anterior folding of the caecum resulting in obstruction, necessitates surgical intervention to alleviate symptoms and prevent recurrence. While initially, simple reduction was attempted, it often resulted in high rates of recurrence. Consequently, more definitive procedures like caecopexy, or resection and anastomosis, have gained favor. However, the comparative effectiveness of caecopexy versus resection and anastomosis remains unclear due to the scarcity of large-scale studies. The rarity of caecal bascule hampers evidence-based recommendations regarding the optimal surgical approach. Thus, there is a pressing need for prospective studies to evaluate outcomes, recurrence rates, and long-term complications associated with each procedure. In summary, although surgical intervention is essential for managing caecal bascule, the choice between caecopexy and resection with anastomosis depends on clinical judgment and expertise. Further research is imperative to elucidate the superior approach for preventing recurrence and ensuring favorable long-term patient outcomes in this rare condition.

References

1. Rabinovici R., Simansky D.A., Kaplan O., Mavor E., Manny J. Cecal volvulus. *Dis. Colon Rectum.* 1990;**33**(September (9)):765–769.
2. Delabrousse E., Sarlième P., Sailley N., Aubry S., Kastler B.A. Cecal volvulus: CT findings and correlation with pathophysiology. *Emerg. Radiol.* 2007;**14**(November (6)):411–415.
3. Chinoy M., Reyes C.V. Cecal bascule. *Arch. Surg.* 1984;**119**(September (9)) 1099.
4. Bobroff L.M., Messinger N.H., Subbarao K., Beneventano T.C. The cecal bascule. *Am. J. Roentgenol.* 1972;**115**(June (2)):249–252.
5. Lung B.E., Yelika S.B., Murthy A.S., Gachabayov M., Denoya P. Cecal bascule: a systematic review of the literature. *Tech. Coloproctol.* 2018;**22**(February (2)):75–80.
6. de la Hermosa A.R., Ortega-Domene P., Fuenmayor-Valera M.L., Pérez-Morera A., Seoane-González J.B. Caecal bascule, an unusual cause of intestinal obstruction. *Cirugía y Cirujanos (English Edition)* 2016;**84**(November (6)):513–517.