Case Report on Intestinal Obstruction

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Intestinal obstruction exists when blockage prevents the normal fow of intestinal contents through the intestinal tract. Two types of processes can impede this fow: 1) Mechanical obstruction: An intraluminal obstruction or a mural obstruction from pressure on the intestinal wall occurs. 2) Functional or paralytic obstruction: The intestinal musculature cannot propel the contents along the bowel. The blockage also can be temporary and the result of the manipulation of the bowel during surgery.

Pain in the lower abdomen, not passed stools and gases, fever (99.6°C), nausea vomiting.

Height: average, Weight: 50 kg, Blood pressure: 110/70, pulse: 78 b/m, Respiration: 18b/m Temperature: 98.6

Hb=10%, PLT= 3.7, HBSAG- non reactive Blood test: Hb – 9.7gm%, APTT= 29.50, PLT=3.72, HBsAg – non reactive, CEA= 0.73, CA 125= 11.9, Peripheral Smear: RBCs- Normocytic mildly hypochromic RBCs seen. Platelets- Increased on smear. No hemiparasite seen.

My patient aged 20 years old female was admitted to surgery ward intestinal obstruction and she had complained of lower abdominal pain, not passed stool for 3 days and fever.

Intestinal obstruction; Intestinal volvulus

Introduction

Intestinal obstruction exists when blockage prevents the normal ow of intestinal contents through the intestinal tract [1]. Two types of processes can impede this ow.

1. Mechanical obstruction: An intraluminal obstruction or a mural obstruction from pressure on the intestinal wall occurs.
2. Functional or paralytic obstruction: e intestinal musculature cannot propel the contents along the bowel. e blockage also can be temporary and the result of the manipulation of the bowel during surgery [2,3].

An intestinal obstruction is one of the frequent surgical disorders in general surgical practices. Bowel obstruction can be classi ed in to various types. It can be mechanical or non-mechanical according to the mode of obstruction. Impairment to the abnormal passage of intestinal contents can result from either a mechanical obstruction to the bowel or even failure of normal intestinal motility in the absence of an obstructing lesion [4].

Patient Information

A female 20 years from Wardha was admitted to surgery ward no- 28, AVBRH on 30 May, 2021 diagnosed as the case of intestinal obstruction. She weighs 30 kgs with a height of 150 cms.

Clinical Findings

A female aged 20 years old was brought to AVBRH on 30 may 2021 by her parents with complaints of lower abdominal pain, not passes stool or gases, nausea, vomiting and fever from 3 days for which she was admitted to surgery ward no-28. She is a case of intestinal obstruction and her hemoglobin level at the time of admission was 8.7 gm%. e female is weak and did not attain menarche to date.

Timeline

obstruction on 30/5/2021. Till that duration, she was admitted to the hospital from time to time for the treatment.

Family History

My patient's family comprises four members. She was diagnosed to have intestinal obstruction with no abnormal genetic history from her parents. e parents had a non-consanguineous type of marriage. Except for the patient admitted to the hospital. Other family members don't have any complaints regarding their health.

Diagnostic Assessment

Abdominal pain being the chief complaint of the patient, which was later diagnosed as intestinal obstruction through the report on 30/5/2021.

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in right para-umbilical region with collapsed distal bowel loops. On further palpation it was found to occupy the features suggestive of intestinal obstruction at the level of distal ilium, possibly secondary to adhesion. e girl is thin, weak and has dull look. She is well oriented with the date, time, and place is cooperative.

1. Hb – 9.7gm%, APTT=29.50, PLT=3.72, HBsAg – non reactive, CEA=0.73, CA 125=11.9, Peripheral Smear: RBCs-Normocytic mildly hypochromic RBCs seen. Platelets-Increased on smear. No hemiparasite seen.

2. CECT Abdomen

3. Evidence of abnormal dilation of small bowel noted. e ascending colon, hepatic exure and proximal transverse colon also show dilatation. e transition point suspected at proximal transverse with e/o clumping of mesentery and bowel. ere is suspicion of intussusception at this point. Distal to colon is collapsed.

Mild free uid notes in abdomen and pelvis.

Few 5-7 µm homogeneously enhancing lymph nodes are noted in mesentery, likely reactive.

4. Is normal in size (13.5cm), shape and enhancement pattern. No evidence of EHBD & IHBD is noted. It is normal in size. Intrahepatic part of IVC & hepatic veins is normal.

5. Appears normal. Wall thickness is normal. No evidence of any calculus.

6. Appears normal.

7. Is well de ned no evidence of wall thickening. aty2T0 Tw -1.u-JT10 1fxof waa(ic)6(k)anet(f w(I)22r)13n un034m he(i)1e of wape a5(

2. Nursing diagnosis: Low nutritional pattern less than body requirement related to pain perception secondary related to regurgitation (Table 2).

3.

3. To eat high iron and ber rich diet to enhance the hemoglobin level and immunity of the body.

4. To perform deep breathing and leg exercises or early walking as it reduces the risks of blood clots and chest infections.

Intestinal obstruction isasigni cant mechanical impairment or complete arrest of passage of contents through the intestine due to pathology that causes blockage of bowel. e symptoms are including in that pain in lower abdomen, vomiting, constipation [6]. It is con rmed