

## Letters to the Editor

### Intestinal perforation in the immediate puerperium: A rare complication of bariatric surgery

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*Key words: Intestinal obstruction. Bariatric surgery. Pregnancy. Complications.*

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Dear Editor,

Although intestinal obstruction is a well-known late complication of bariatric surgery techniques (1,2) and can also occur during pregnancy (3,4), the coincidence of both circumstances and its debut as acute abdomen with pneumoperitoneum by drilling intestinal puerperium is exceptional, which encourages us to communicate the following case report.

#### Case report

Female patient of 30-years-old, pregnant of 36 weeks, with previous surgical biliopancreatic bypass (Scopinaro) performed by laparotomy nine years earlier (pre-surgical BMI: 48, pre-gestational BMI: 33), with multiple entries during the 3<sup>rd</sup> trimester due cramping abdominal pains, which were labeling as renal colics (a light right renal hydronephrosis was objectified by ultrasound). Few days later, the patient returns to the emergency room referring an abdominal pain four hours of evolution, with similar characteristics with four hours of evolution, focused on hypogastrium, accompanied by vomiting and absence of fever. Physical examination evidenced diffuse abdominal pain without peritoneal irritation signs, mainly in lower abdomen. The blood test evidenced intense leukocytosis (28,500 leukos/ml, 89.2 % neu-

trophils), CRP 18.4 mg/dl, procalcitonin 3.2 ng/ml and Quick index of 58 %. Although the fetal monitoring did not describe signs of distress, labor induction was decided due clinical suspicion of acute pyelonephritis (given the recent history of the patient). The delivery passed smoothly and a healthy girl of 2,800 g was born by the vaginal via. The next day, coinciding with epidural catheter removal and deletion of continuous infusion of intravenous analgesics, the patient debuts with abdominal hyperacute pain with abdominal defense and marked signs of peritonism. A CT scan was realized (Fig. 1) which reported pneumoperitoneum with free fluid and diffuse thickening and distension of small bowel. The patient underwent an emergency laparotomy, which revealed a peritonitis secondary to intestinal perforation of the Scopinaro's jejunoileal anastomosis due traction from firm flange on the ileal common loop. A primary closure of the perforation and abdominal lavage were done. The postoperative course was uneventful.

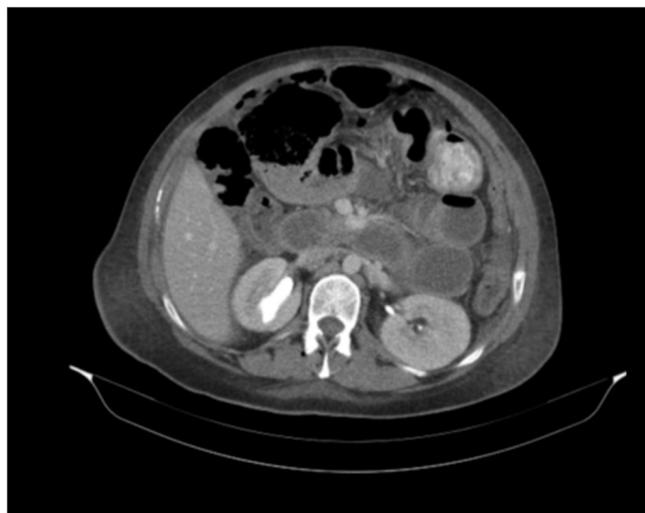


Fig. 1. Abdominal-pelvic CT showing pneumoperitoneum, free fluid and thickening-distension of small bowel loops.

## Discussion

The presentation of an acute abdomen during the third trimester and puerperium is often difficult to diagnose, due the abdominal pain is interpreted by pregnant women as something normal and expected, otherwise, clinicians tend to relativize it, since the abdominal discomfort is usual and besides, the surgical causes are rare uncommon (such as acute appendicitis, inguinal-femoral hernias or colonic volvulus) (5,6), not to mention the relative contraindication of using conventional radiography during pregnancy, all of these circumstances make the diagnosis of intestinal obstruction difficult; which in our clinical case, passed as a subocclusive adhesive process (postsurgical intestinal flange over the yeyuno-ileal anastomosis from the ileal common loop), unnoticed and hidden under the diagnosis of several renal colics and finally complicated with perforation and peritonitis, which also were initially masked by the regular analgesia administered before and during labor.

As a final conclusion, although the most common cause of colic abdominal pain in pregnant women, excluding uterine contractions, is the renal colic (5,6), intestinal obstruction should also be present in the differential diagnosis, especially in patients with history of abdominal surgery.

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