IMJ
Official Journal of the Irish Medical Organisation

Ir Med J; April 2024; Vol 117; No. 4; P951
25th April, 2024

Navigating the Maze: A Unique Case of Intestinal Obstruction in Late Pregnancy

S. Memon, S. Lal, J. Thomas

Department of Anaesthesia, Critical Care Medicine and Pain Management, Our Lady of Lourdes, Hospital, Drogheda, Co. Louth, Ireland.

Dear Editor,

We present a compelling case of intestinal obstruction in a late-stage pregnant patient, underscoring the diagnostic and therapeutic challenges acute abdominal pain poses during pregnancy.

Acute abdominal pain in pregnant women presents a diagnostic challenge due to its broad differential diagnosis encompassing both obstetric and non-obstetric causes. Intestinal obstruction is rare during pregnancy, with incidence rates between 0.001% and 0.003%, yet it significantly increases maternal and foetal mortality, necessitating swift and precise intervention.

A 39-year-old woman, gravid 3, para 2, at 33+3 weeks of gestation, presented with progressive lower abdominal pain. Past medical history was unremarkable except for two previous spontaneous vaginal deliveries. Initial Ultrasound showed a normal pregnancy progression but revealed iliojejunal distention. Her condition deteriorated over the next few days, suggesting intestinal obstruction. Conservative treatments failed, leading to her transfer to a high-dependency unit. An abdominal MRI confirmed intestinal dilatation. An emergency caesarean section, followed by laparotomy and adhesiolysis, was performed, resulting in the birth of a healthy neonate. The patient's postoperative course was uneventful, and she was discharged home.

Intestinal obstruction in pregnancy, particularly in the later stages, often necessitates surgical intervention. The most common aetiology is post-surgical adhesions, but other causes include volvulus, intussusception, hernias, tumours, or idiopathic ileus. Diagnosis is challenging due to the enlarged uterus distorting physical findings and concerns over imaging modalities' safety. Ultrasound is preferred for initial evaluation; however, MRI is invaluable for detailed imaging when available. Treatment mirrors that of the non-pregnant population, emphasizing

non-surgical management initially, with surgery reserved for conservative treatment failure or evidence of foetal distress or severe bowel compromise.

Obstetricians should maintain a high index of suspicion for bowel obstruction in pregnant women, especially those with a history of abdominal surgery. Prompt diagnosis and a multidisciplinary treatment approach are crucial, balancing conservative management with timely surgical intervention to safeguard maternal and foetal well-being.

Declarations of Conflicts of Interest:
None declared.

Corresponding author:
Shankar Lal,
Our Lady of Lourdes Hospital,
Drogheda,
Co. Louth,
Ireland.
E-Mail: Shankar.anaesthesia1@gmail.com

References:

1. Sivanesaratnam V. The acute abdomen and the obstetrician. Baillieres Best Pract Res Clin Obstet Gynaecol. 2000;14:89–102.
2. Perdue PW, Johnson HW, Stafford PW. Intestinal obstruction complicates pregnancy. Am J Surg. 1992;164:384–8. https://doi.org/10.1016/s0002-9610(05)80910-9.
3. Jackson P, Vigiola CM. Intestinal Obstruction: Evaluation and Management. Am Fam Physician. 2018;98:362–7.