Traumatic Rupture of Duodenum: A Case Report

History and Physical Exam:

The patient was a 32-year-old male with a history of blunt abdominal trauma. He had been involved in a car accident four hours prior to presentation. The patient complained of severe abdominal pain, nausea, and vomiting. On examination, there were no peritoneal signs, but the patient had a distended abdomen with a palpable mass in the right upper quadrant.

Initial Evaluation:

The patient was assessed with sonography for trauma (FAST), which was negative. Emergency computed tomography (CT) scan revealed a large fluid collection with air in the right upper quadrant, consistent with a perforated viscus. Serum amylase and white blood cell (WBC) count were also performed.

Treatment:

The patient was taken to the operating room for exploratory laparotomy. A large perforation of the duodenum was found, and the perforation was repaired. Postoperatively, the patient was treated with antibiotics and nasogastric tube decompression. He made an uneventful recovery and was discharged on the fifth postoperative day.

Discussion:

Traumatic duodenal perforation is a rare occurrence, but it is important to recognize as it can lead to severe complications if not managed promptly. Early recognition of peritoneal signs is crucial, but they may be absent in up to 40% of cases due to the anatomical location of the duodenum. In such cases, a high index of suspicion is required.

Conclusion:

The case highlights the importance of a thorough history and physical examination, as well as the use of imaging modalities such as CT scan, in the diagnosis of traumatic duodenal perforation. Early recognition and prompt intervention are critical for a favorable outcome.
Traumatic Rupture of Duodenum: A Case Report

Introduction

The incidence of duodenal rupture has been estimated at 1.1% in patients with small bowel perforation (SBP). The management of duodenal injury and small bowel perforation (SBP) remains controversial, and the decision to operate or observe depends on the patient's clinical condition, the extent of the injury, and the operator's preference. The present case report describes a 48-year-old man with a history of blunt trauma who presented with abdominal pain and tenderness. The patient was initially managed conservatively, but due to persistent abdominal pain and the presence of a right lower quadrant mass, the patient was further worked up and found to have a duodenal rupture.

Methods

The patient was initially managed conservatively with pain control and observation. However, due to persistent abdominal pain and the presence of a right lower quadrant mass, the patient was further worked up with computed tomography (CT) and ultrasonography. The CT scan revealed a thick-walled, enhancing mass in the right lower quadrant, consistent with a duodenal rupture. The patient was then taken to the operating room for exploratory laparotomy.

Results

At the time of surgical exploration, the duodenal injury was identified and repaired with a Douchet-Billroth procedure. The patient's postoperative course was uneventful, and he was discharged home on the 7th postoperative day.

Conclusion

The management of duodenal rupture remains controversial, and the decision to operate or observe depends on the patient's clinical condition, the extent of the injury, and the operator's preference. In this case, the patient was managed conservatively initially, but due to persistent abdominal pain and the presence of a right lower quadrant mass, the patient was further worked up and found to have a duodenal rupture, which was repaired with a Douchet-Billroth procedure. The patient's postoperative course was uneventful.

Conflict of Interest

The authors have no conflicts of interest to disclose.
Traumatic Rupture of Duodenum: A Case Report

Table II: Rome III Diagnostic Criteria for Pediatric Functional Bowel Disorders.

EMCJ. Jan 2016: 1 (1)

...and family's search for a physical cause and allows but not life-threatening is essential. When understood...
Traumatic Rupture of Duodenum: A Case Report

Abstract

Duodenal rupture is presented to highlight these issues.

Introduction

Delays in presentation, lack of optimal diagnostic approach & delayed surgical intervention have resulted in many patients with SBP could be determined no clear cut-off value that could help differentiate anaesthesia were done & Patient was prepared for. This is a story of a 20 years old boy. He had a history of injury and small bowel perforation (SBP) 1.1% and occurring in an emergency surgical unit and Blunt pain associated with altered bowel pattern. for pain or nonstimulating laxatives or antidiarrheals for time-limited use of medications that might help to relieving hyperalgesia. The 'red flag' signs have long been used by clinicians to identify patients with functional abdominal pain. Some children with functional abdominal pain may have more than one of these signs. The role of psychosocial stressors. However, pain may diminish and recede if the child's life situation improves or if they make a change in their lifestyle. In small gut perforations the mucosa may prolapse induced by the nearly neutral intestinal content.

Case Report

Clinical Features:

1. Pain associated with altered bowel pattern.
2. Tenderness in the left lower quadrant.
3. Elevated white blood cell count.
4. Elevated serum amylase levels.
5. Increased serum lactic dehydrogenase levels.
6. Radiographic evidence of free intraperitoneal air.
7. Abdominal distention.
8. Marked leukocytosis.
9. Elevated serum C-reactive protein levels.
10. Positive findings on computed tomography scan.

Results:


Discussion:

EMCJ. Jan 2016: 1 (1)