

Jejunal diverticulitis

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Dear Editor,

Jejunal diverticulosis is the least common type of small bowel diverticula, incidence is less than 0.5% (1). Jejunal diverticulitis (JD) was first reported in 1807 by Sir Astley Paston Cooper. Autopsy studies reveal an incidence between 1.3% and 4.6%, whereas radiologic studies show an incidence between 0.02% and 2.3% (2). Major complications include diverticulitis, gastro intestinal hemorrhage, intestinal obstruction, acute perforation. Mortality is influenced by patients' age, nature of complications, and time of intervention. Common acute complications include diverticulitis, bleeding, intestinal obstruction and perforation (3). The mortality rate of complicated jejunal disease has ranged between 21% and 30% over the past 30 years (4); however, some reviews indicate a mortality rate between 0% and 5% (5). These reviews may reflect improvements in intensive care management and antimicrobial treatment.

In this case thirty five years old male patient with a complaint of a day earlier with abdominal pain, nausea and loss of appetite were admitted to our clinic. The patient did not have any previous history for disease and operation. On physical examination, 37 °C temperature, heart rate 100/min, blood pressure 90/50mm Hg and respiratory rate 16 breaths/min., Oxygen saturation of 97% on room air. Had hypoactive bowel sounds and abdominal tenderness positive. Rebound and defense has been detected in the right lower abdomen. Laboratory findings, white blood cell levels 13000/ mm³ and other parameters were normal. Standing in direct abdominal X-ray bowel air-fluid levels detected. Ultrasonography (USG) examination revealed minimal fluid collection between intestinal loops. The present findings resembled appendicitis. We performed diagnostic laparoscopy Inspectional findings for appendix was normal, but purulent contents were detected among intestinal loops. But we did not find any pathology explain this purulent liquid. So we performed laparotomy. We found JD had settled on to the mesentery 60 cm from Treitz. (Figure 1)

There was inflammation around diverticulitis. There is no perforation so resection was not considered. Abdomen was washed with plenty of SF and operation has been terminated. After surgery antibiotic therapy was started. Oral intake was stopped for two days. Than oral regime was opened on the third day. Abdominal examination

was completely normal and post-operative fourth day the patient was discharged.



Figure 1. Jejunal diverticulitis in operation

As a result, the JD is rare and difficult to diagnose. Although conservative medical management may be attempted for stable patients, surgical resection of involved bowel segments is the standard of care for patients with recurrent symptoms who have undergone unsuccessful medical management or have complications. Mesenteric localized JD confused with other disorders causing acute abdominal pain and may cause unnecessary laparotomies. We should kept in mind that JD may be among the causes of acute abdomen. In addition, diagnostic laparoscopy can be a valuable diagnostic tool in complex cases.

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