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Yeşim ÖZTÜRK[1], Hasan ÖZEN[2], Ender PEHLİVANOĞLU[3]

Department of [1]Pediatrics, Dokuz Eylul University School of Medicine, İzmir

Department of [2]Pediatrics, Hacettepe University School of Medicine, Ankara, Turkey

Department of [3]Pediatrics, Marmara University School of Medicine, İstanbul, Turkey

Small bowel volvulus secondary to post appendectomy adhesion band

Apendektomi sonrası gelişen adezyon bandına bağlı incebarsak volvulusu

To the Editor,

A 66-year-old woman was admitted to the emergency department with a complaint of severe abdominal pain, nausea, and vomiting. She had a history of previous appendectomy 36 years ago. The abdominal examination revealed moderate distension and rebound tenderness. The white cell count revealed a leukocytosis (35.500/mm^3). Abdominal computerized tomography (CT) revealed segmental intestinal dilatation. At laparotomy, a twisted jejunoileal segment 50 cm in length was twisted around a tight adhesion band starting from the appendocecal peritoneum to the small bowel mesentery. Segmental jejunoileal resection and primary end-to-end anastomosis was performed. The patient was discharged uneventfully on the nineth day of admission.

A 48-year-old woman was admitted to the emergency department with severe abdominal colicky pain. She had a history of previous appendectomy due to perforated appendicitis 18 years ago. Abdominal examination revealed extreme distention and rebound tenderness. She had a leukocytosis of 18.400/mm^3. Abdominal CT showed diffuse intra-abdominal fluid accumulation. Laparotomy was performed and an approximately 30 cm ileal volvulus was discovered around an adhesive band beginning from underneath the appendectomy incision to the small bowel mesenteric root (Figure 1).

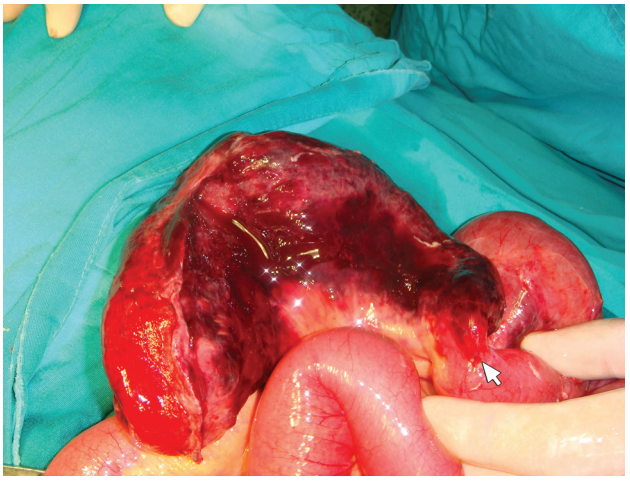

Figure 1. Laparotomy showed a twisted small bowel segment and compressed by adhesive band.

Address for correspondence: Zülfikar KARABULUT
Department of General Surgery, Başkent University Hospital, Antalya, Turkey
E-mail: drkarabulut33@yahoo.com

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Segmental ileal resection and end-to-end anastomosis was performed. On the sixth day of admission she was discharged uneventfully.

Primary small bowel volvulus (SBV) occurs in the absence of anatomic abnormalities or predisposing factors. Although very rare in USA and Western Europe, the incidence is 5-10 times higher in Africa, Asia, and Middle East. It is thought to be related to different dietary habits such as ingestion of large volumes of fiber-rich foods after long intervals of fasting (1,2).

Secondary SBV occurs generally in the presence of predisposing factors such as anatomic disorders, malrotations, or postoperative adhesive bands. Post-operative adhesive bands are major problems for all surgeons due to their morbidity (1-3).

Post operative adhesive small bowel obstruction is a rare but documented complication of appendectomy. The frequency of this condition has been reported between 0,2 % and 10,7 % (4). Due to its rarity, long-term severe complications of appendectomy are generally neglected.

Abdominal CT has been shown to be effective for the diagnosis of strangulation of the affected bowel with a high specificity and sensitivity of 93% and 83% respectively (5). When the characteristic "whirl sign" is seen on CT scan, SBV should be suspected (5,6). SBV is an extremely rare but potentially fatal condition that should be kept in mind in all patients with severe abdominal pain. Previous abdominal operations are thought to be an etiologic factor of SBV.

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Zülfikar KARABULUT, Paşa DOĞAN

Department of General Surgery, Başkent University Hospital, Antalya

A duodenal mass and acute pancreatitis

Duodenal kitle ve akut pankreatit

To the Editor,

Eosinophilic gastroenteritis (EGE) is a rare condition, first described in 1937 by Kaijser *et al.* It is defined as a disorder primarily affecting the gastrointestinal tract with eosinophil-rich inflammation, in the absence of known causes of eosinophilia (e.g. drug reactions, parasitic infections, or malignancy) (1). Three different forms of EGE can be distinguished: mucosal disease, muscle layer disease, and subserosal disease. The symptoms of EGE are related to the layer involved. Mucosal disease is the most common form and presents with nonspecific symptoms such as abdominal pain, nausea, vomiting, diarrhea, or malabsorption. The second form, muscle layer disease, is a more serious form that presents with symptoms due to intestinal obstruction. The third form, subserosal di-

Address for correspondence: Özlem ÖZER ÇAKIR
Selcuk University, Meram School of Medicine, Department of Gastroenterology and Hepatology, Konya, Turkey
E-mail: tansozlem@yahoo.com

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