CASE REPORT

Delayed Diagnosis of Tubular Ileal Duplication

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ABSTRACT

Alimentary tract duplications have varied presentation and are often misdiagnosd. A 5-year-old girl presented with abdominal pain, vomiting, and bleeding per rectum. She had a long history of various gastrointestinal symptoms and was being managed as a case of celiac disease. Ultrasound abdomen during current admission suggested an intussusception. At operation, a long tubular communicating duplication of ileum was found. Resection and end to end anastomosis was curative.

Key words *Duplication cyst, Ectopic gastric mucosa, GIT bleeding.*

INTRODUCTION:

The presentation of gastrointestinal tract (GIT) duplications depends upon site, size, communication with normal GIT, presence of ectopic gastric or rarely pancreatic mucosae, and related complications.[1] At times nonspecific symptoms may misdirect the treating clinicians. Herein a case of ileal tubular duplication cyst is being reported who was receiving treatment of celiac disease.

CASE REPORT:

A 5-year-old girl,weighing 12kg, presented with abdominal pain, vomiting, and bleeding per rectum for 5 days. She was on follow-up of Gastroenterology department as a case of celiac disease. Past medical history revealed multiple episodes of abdominal pain, non-bilious vomiting, failure to thrive, loose stools, occasional distension, and bleeding per rectum for the last 3 years. The bleeding per rectum was significant and she received multiple blood transfusions for that. She had undergone colonoscopy and upper GIT endoscopy. Jejunal biopsy showed mild enteritis. She was on gluten free diet for the last 2 years.

During current admission, ultrasound abdomen suggested an intussusception. On examination patient was vitally stable with slight pallor. Abdominal examination revealed mild tenderness in the periumbilical region. No mass was palpable. Laboratory parameters were within normal limit. At operation, a long tubular duplication of mid ileum (40cm) was encountered running along its mesenteric border and sharing a common wall and mesentery throughout its extent.The proximal end of the duplication was dilated like apouch (Fig. I) and its distal end had a small communication with the ileum. The entire duplication along with intimately attached ileum was resected and end to end anastomosis done. Postoperative recovery was uneventful. The histopathology of the specimen confirmed it as duplication cyst with ectopic gastric mucosa. She was started slowly on normal diet. At one month follow-up, she had gained 0.5kg weight.

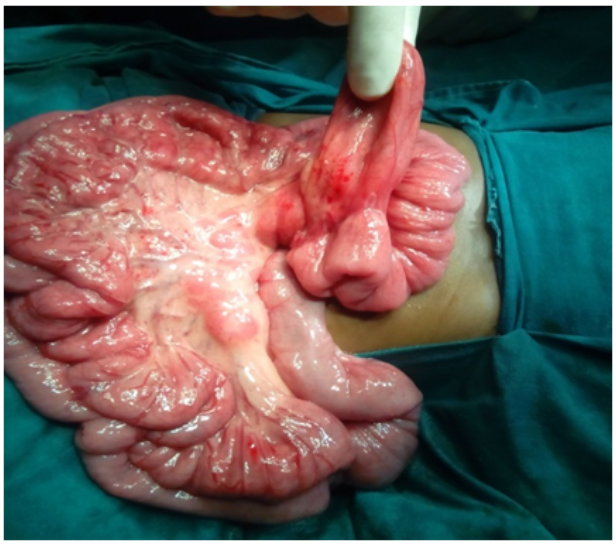

Fig I: Duplication cyst with proximal dilated part. (lifted up).

DISCUSSION:

Despite being a well-known pediatric surgical entity, the literature about GIT duplications is constantly emerging highlighting new aspects. Small

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bowel duplications are most common GIT duplications and about 20% are tubular and 20% communicating.[2] Clinical presentation, complications, and anatomical features of the GIT duplication have surgical implications.[1-3] Duplication cyst may remain asymptomatic for decades and diagnose incidentally on abdominal imaging done for other reasons. On the other hand, it may present as an acute abdomen necessitating urgent laparotomy to salvage normal intestine.[4]

The index patient had usual signs of GIT duplication with ectopic gastric mucosa but these were not picked up. At operation the duplication and attached normal bowel were sharing same blood supply. It was not possible to remove a long strip of mucosa, thus resection was chosen though a significant length of bowel was lost. The rest of the bowel was sufficient in length along-with competent ileocecal valve. Postoperatively the girl did put on weight in short span of time. GIT duplications can present in many ways. A delay in diagnosis can be avoided if varied presentations of GIT duplications are kept in mind.

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