Letter to the Editor: Man with Acute Abdomen

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Dear Editor,

We would like to share our input on the recently published quiz "Man with Acute Abdomen" by Kyaw et al.[1] According to the authors, the pathogenesis of pneumatosis intestinalis is possible to be multifactorial with unestablished pathogenesis. One of the causes that sparked our attention is the relationship between pneumatosis intestinalis and chemotherapy. We reported a similar discovery in which our patient was discovered with pneumatosis intestinalis after a course of palliative chemotherapy for metastatic gastric malignant melanoma.[2] Patient can present in various ways ranging from acute dyspepsia to acute abdomen. The presentations usually correspond to the underlying pathology and therefore hard to predict as it mimics other surgical pathology. As opposed to the authors' case, whereby patient presented with lower gastrointestinal symptoms, our patient presented with upper gastrointestinal tract features.[2] The gold standard in the identification of pneumatosis intestinalis includes contrast-enhanced computed tomography scan. Features suggestive on CT which is seen as eccentric gas bubbles tracking along the inner wall of the gastrointestinal tract separating the intraluminal gas are pathognomonic for pneumatosis intestinalis.[3] Occasionally, pneumatosis intestinalis is associated with hepatic-porto-venous gas (HPVG). However, this secondary sign is not always present in all cases and absence of this signs does not rule out pneumatosis intestinalis. Management strategy includes identifying the etiology and managing it accordingly. Treatment modalities varies from non-operative to operative management. Non-operative management includes adequate hydration, intravenous antibiotic, intravenous analgesia, adequate enteral or parenteral nutrition and bedside abdominal drain to reduce the sepsis. Operative management includes damaged control surgery with stoma creation. Very rarely, bowel resection and primary anastomosis is done as usually these subsets of patients have limited physiological reserve coupled with immunocompromised state secondary to chemotherapy[4]. A minority of cases ended up with mortality, especially among the advanced state of malignancy including our case.[2]

References

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