An unusual cause of intestinal obstruction in pregnancy

Sir,

Acute pain in abdomen during pregnancy presenting with shock can be due to various reasons. We encountered a 32-year-old G4P3L3 mother at 16 weeks of gestation in our emergency department who had pain in her abdomen and bilious vomiting lasting 3 days. Severe pallor was noted. The pulse rate was 110 min^{-1} and the blood pressure was 90/40 mmHg. Bowel sounds were absent. An emergency bedside ultrasound showed a fetus of 15 weeks 5 days of gestation in the right lumbar region along with free fluid and few dilated bowel loops. An emergency laparotomy was done, in which 2.5 l of hemoperitoneum was drained. A massive dilatation of small bowel loops and unicornuate uterus was noted with rupture of communicating rudimentary horn. The en-caul fetus, along with organized clot due to initial retraction of clot fibrin, was adherent in the vicinity of the cornual rent with the adjoining bowel loops and was found to be the cause of mechanical obstruction of the bowel proximal to it. Gentle removal of the fetus and the clots relieved the obstruction. The cornual rent was repaired. The patient stood the procedure well.

We highlight that in the absence of any significant past obstetric history or history of surgery, the intraoperative findings of fetus en caul that causes intestinal obstruction following rupture of rudimentary horn of unicornuate uterus presented an interesting clinical situation.

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Birdshots in brain

Sir,

Cranial traumas from birdshot wounds are serious and life-threatining injuries. Although penetrating brain injury (PBI) is less frequent than closed head trauma, it carries a worse prognosis.[1] Computerized tomography (CT) scan is essential in the emergency setting for initial evaluation of traumatic bone and parenchymatous injuries to determine the indication of neurosurgery and for appropriate medical management. However, CT is recommended as the neuroradiologic modality of choice for the PBI patients.[1] The most significant problem with CT in bridshot wounds is metallic streak artifact.[2] A 2-year-old boy was admitted to the pediatric intensive care unit for eye and brain injury. He had been wounded by birdshot. Cranial CT showed multiple hyperdense birdshots with streak artifacts within the posterior fossa and the occipital lobe [Figure 1a and b]. The birdshots located in orbita bones and different regions of the brain were evaluated as inoperable by neurosurgeons. In patients with gunshot wound in brain, the length of bullet track, the location, and the number of ricochets have a direct correlation with prognosis.[2] Also, intraventricular hemorrhage and bi- or multilobar injury predict poor prognosis.[3] Our patient had long bullet tracks (from orbita to occiput) without intraparenchymal and intraventricular hemorrhage.

Although birdshot injuries in brain are life-threatining traumas, our patient was discharged without any neurological deficiency despite many number of the birdshots and long bullet tracks in the brain. The prognosis of the patients with birdshot injury in brain with long bullet tracks may be good if there is no intraparenchymal or intraventricular hemorrhage.

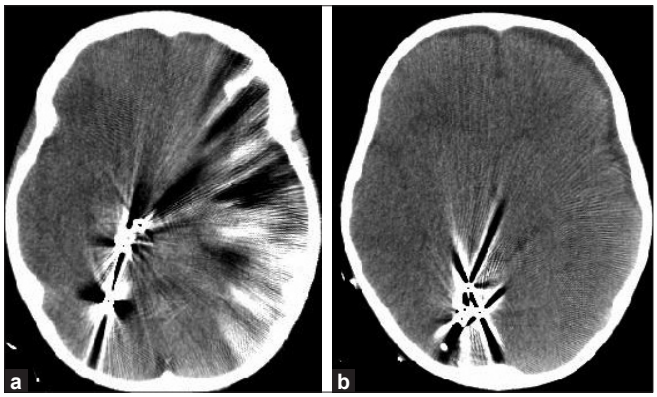

Figure 1: Axial consecutive CT images show multiple hyperdense birdshots with streak artifacts within the posterior fossa (a) and the occipital lobe (b). No prominent intraparenchymal hemorrhage is seen. Note the small amount of subdural effusion over the left frontal lobe

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Traumatic Brown-Séquard syndrome

Sir,

Stab wounds of the spinal cord are rare occurrences and are reported to represent 26% of all spinal cord injuries; motor vehicle accidents and gunshots are responsible for most of them. [1] We present a rare case of particularly violent self-inflicted stab injury with the steel weapon transfixing in an exceptionally precise and forceful way, the neck and the spine.

A 72-year-old woman with a long term history of major depression attempted suicide by stabbing herself in the anterior neck. She was brought to our Emergency Department with a knife still deeply stuck in the jugular notch. She was alert, quiet and calm and clinical examination revealed neither cardiorespiratory nor neurological deficit. On CT-scan the blade penetrated transversally the anterior neck, displaced the trachea and the oesophagus avoiding all major vascular structures, pierced the vertebral body at Th_1 level and traversed the spinal canal with its tip lodged in the left lamina of the first thoracic vertebra [Figure 1]. A surgical intervention was performed in order to explore the wound and remove the blade from the vertebral soma; all great vessels and the trachea were preserved and a small lesion of the oesophagus' serosa was treated by simple stitches. After extubation, hoarsness was observed and a left vocal cord paralysis due to a lesion of the recurrent nerve was documented by fiberoptic laryngoscopy. Moreover, a left spastic hemiparaplegia and an asymmetric sensitivity impairment with right preponderance below Th_4 level occurred, a condition known as incomplete Brown-Séquard syndrome. MRI revealed myelopathy with haemorrhagic components at Th_{1-2} level. Despite early rehabilitation and intensive physiotherapy, no neurologic improvement was observed at 6 months.

Figure 1: This 3D CT-reconstruction shows the blade that pierces through the vertebra till the posterior arch

Stab injuries of the spine are rare, and usually inflicted from behind; most commonly they involve the cervical and upper dorsal spine and two-thirds of victims[2] show an incomplete cord injury with Brown-Séquard or Brown-Séquard-plus syndrome,[3] less frequently intradural or epidural hematoma. Concurrent injuries can affect every organ. A CT-scan is recommended in order to evaluate the relation between the blade and the anatomical structures, especially the spinal cord, to plan the surgical approach. The aim of surgical treatment is to remove the blade, to decompress the spinal cord if necessary, avoiding secondary spinal damage[1] due to edema or hematoma and to close any dural tears to prevent a cerebrospinal fluid leak.

In patients with incomplete spinal cord stab injuries, prognosis is fairly good with recovery being reported in about 50-60% of incomplete injuries,[1] unless MRI shows a hemorrhage into the cord.[4] Our patient had an unlucky evolution; the secondary lesion after blade removal caused more deficits than the primary lesion with sequelae persisting unvaried at 6 months.

This case presents a unique scenario (to our knowledge only one further case of self-inflicted Brown-Séquard syndrome related to "stab" injury is reported in literature[5]) in which the self-inflicted knife stab was forceful enough to transfix the neck, to pierce the vertebral body and traverse the spinal canal without causing neurological deficits, which eventually occurred after blade removal.