

Episodes of abdominal pain

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CASE REPORT

A 63-year-old lady presented with abdominal pain after an abdominal perineal rectum amputation (APR) combined with an end colostomy for a T₃N₁ adenocarcinoma, in 2008.

In the last year, she had undergone 15 episodes of abdominal pain similar to the current presentation, resulting in many visits to different hospitals, some leading to admission. During analysis, several X-rays showed signs of an ileus. However, no cause could be identified in any of the presentations and the patient recovered spontaneously. During her last admission, she presented with pain in the epigastric region which had persisted for the last 24 hours and radiated to the umbilicus. Simultaneously stoma production stopped, despite using Movicolon four times a day on a regular basis. Physical examination revealed no abnormalities, besides obesity. The stoma looked vital and digital examination showed no abnormalities. As contrast colography showed a stenosis at 15 cm oral to the stoma, a colonoscopy was performed, showing no abnormalities.

Figure 1.



Again, the patient recovered uneventfully and a CT was ordered as part of her follow-up (*figure 1*).

WHAT IS YOUR DIAGNOSIS?

See page 228 for the answer to this photo quiz.

DIAGNOSIS

The scan revealed a parastomal hernia including small bowel loops. Parastomal hernia is a common late complication of end colostomy, with an incidence up to 50%, depending on stoma type and length of follow-up.¹ Most parastomal hernias are asymptomatic, although many patients experience discomfort or pain and intermittent episodes of obstruction. In addition, even severe life-threatening complications can occur such as strangulation, perforation and total obstruction.

Often, these hernias are caused by surgical-related problems, such as the use of a trephine that is too large, or formation outside the rectal muscle. Nontechnical factors are thought to be the same as with other abdominal hernias, including obesity and waist circumference,² malnutrition, high intra-abdominal pressure, corticosteroid use, malignancy, increasing age and postoperative wound infection.¹

Clinical demonstration is not always obvious, and therefore Valsalva manoeuvre and supine position can help to reveal the hernia. As physical examination may be difficult, especially in obese patients, imaging is justified in patients with a high index of suspicion. Both CT scan and ultrasonography can be helpful, although thorough physical examination accompanied by imaging seems to provide the most accurate results.³

Most parastomal hernias are treated conservatively, with or without a stomal supporting device. Intervention is

necessary in case of obstruction or strangulation. As local primary repair or relocation have demonstrated even higher recurrence rates compared with primary stoma formation,¹ research has focused on the use of mesh repair, showing better results.⁴ As a consequence, in the prevention of parastomal hernia, some suggest using the mesh technique in primary stoma formation.

In patients with a stoma and abdominal pain, a parastomal hernia should be considered. In case of a high index of suspicion of a parastomal hernia, imaging is an important diagnostic tool besides physical examination.

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