Radiology Elective Case Presentation

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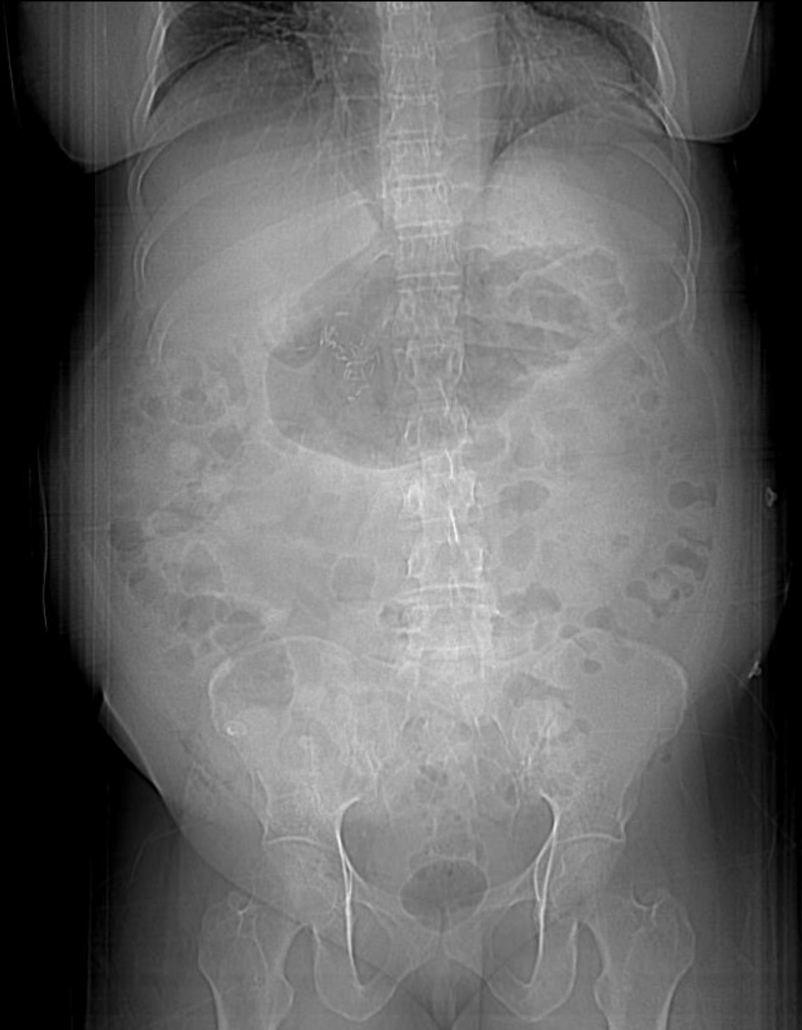
Yale SCHOOL OF MEDICINE

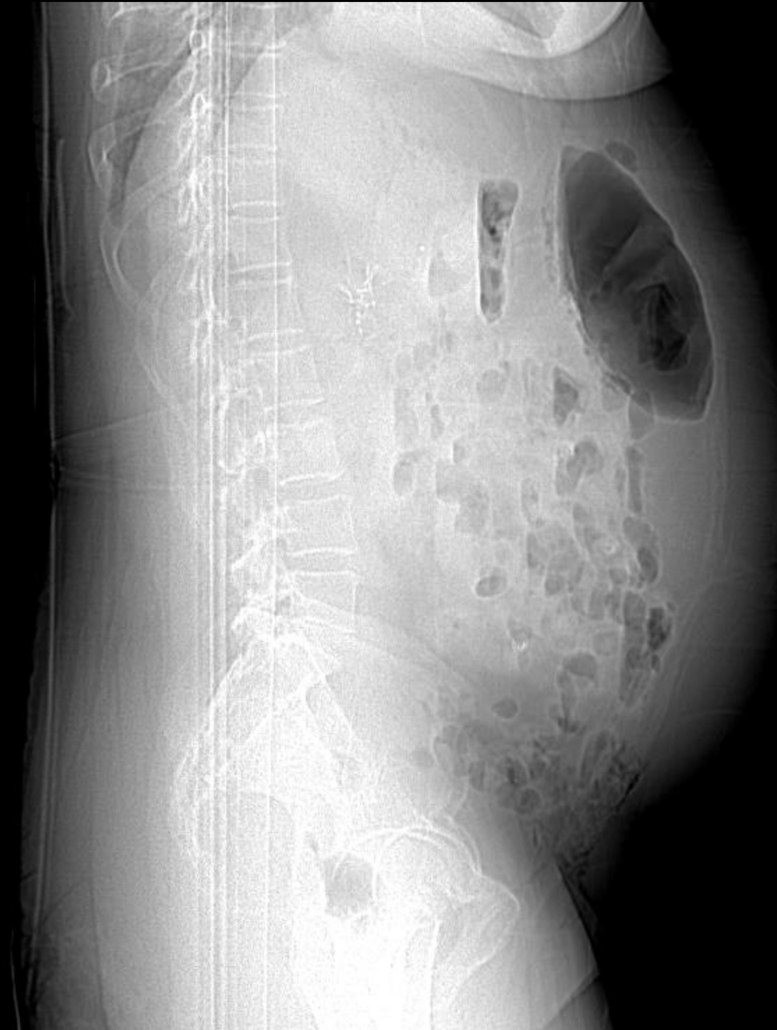
History

- 51yF on immunosuppressants s/p liver transplant in 2009, s/p ventral hernia repair in 2010, recently s/p elective hernia repair 1 week prior – now presenting to clinic with lower abdominal pain, N/V, dysuria, and chills
- Vitals: BP 116/65, HR 103, T 101.2F
- Patient noted to be ill-appearing on exam, generalized abdominal tenderness without rebound
- WBC 28.3
- Sent to ED for CT Abdomen Pelvis + IV Abx

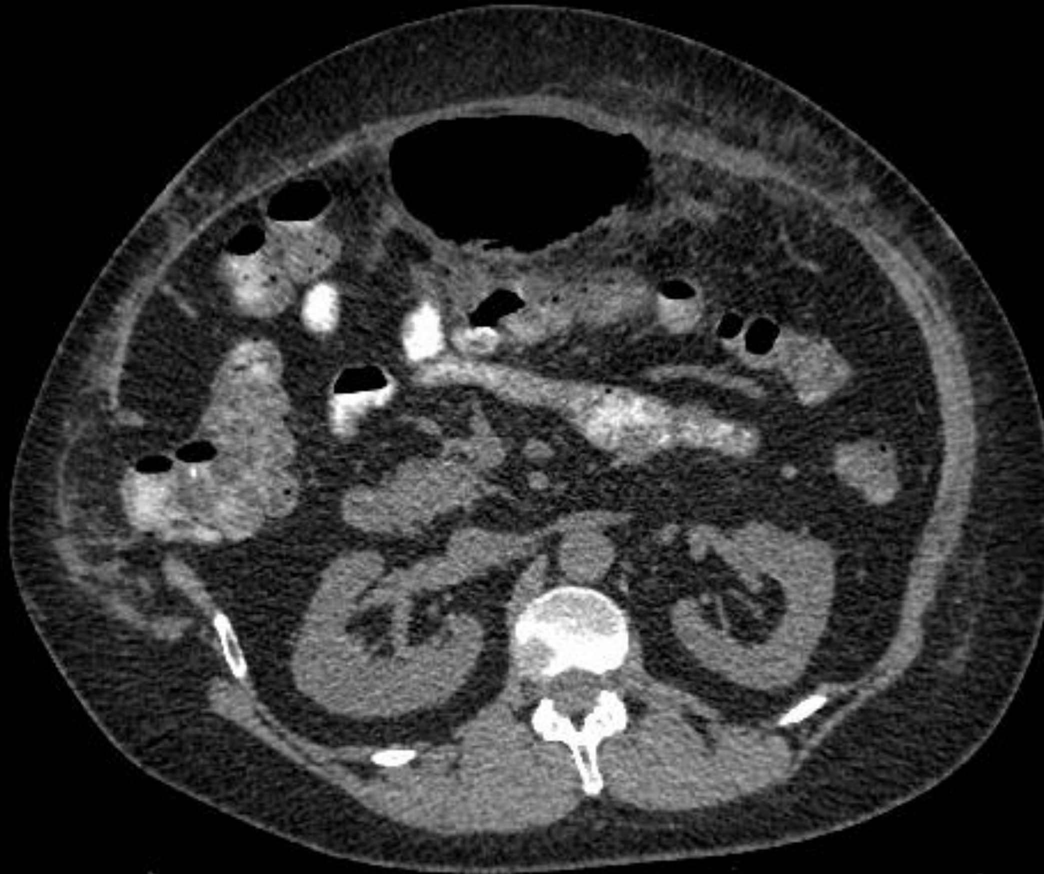
CT Abdomen Pelvis Scout - Supine



CT Abdomen Pelvis Scout - Lateral

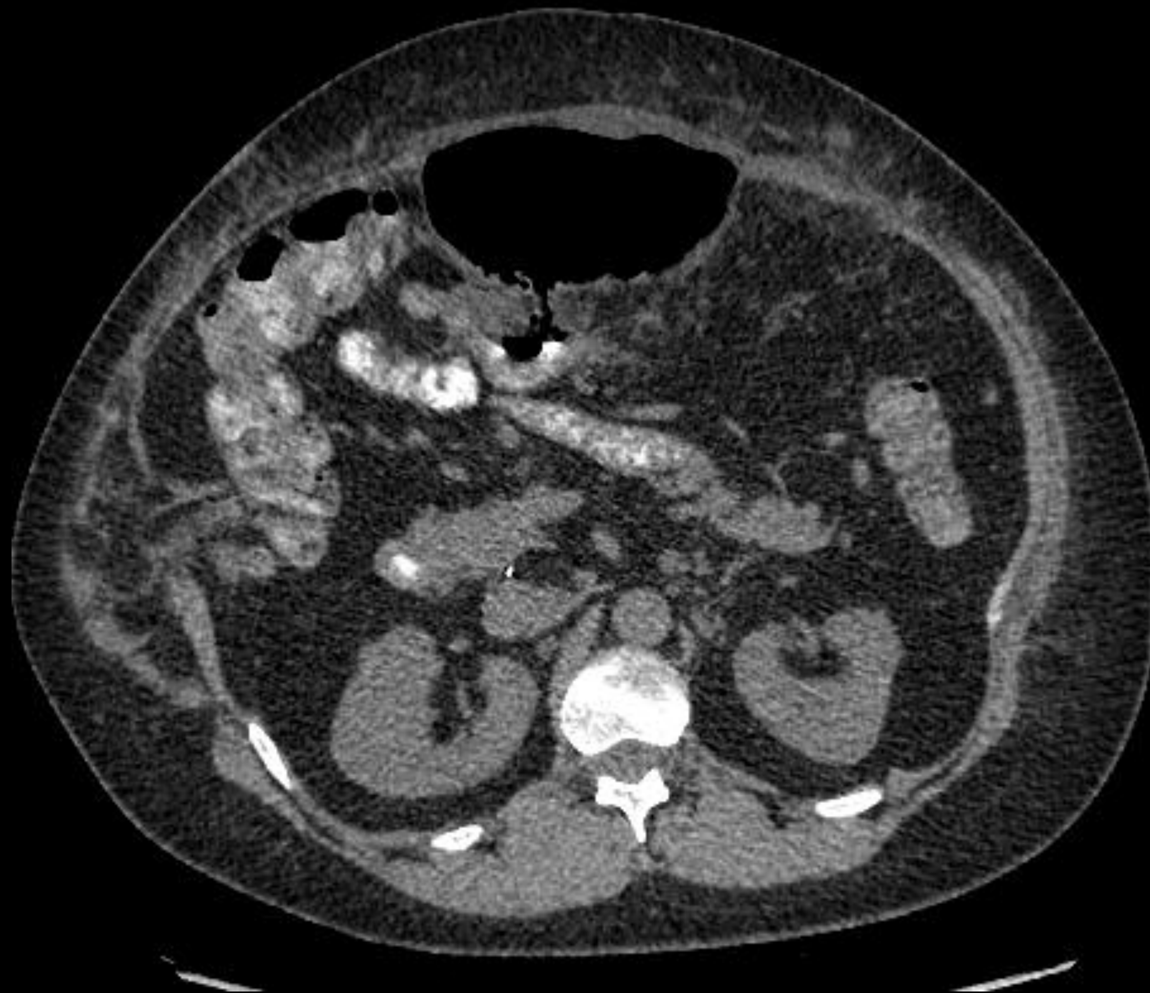


CT Abdomen - Transverse

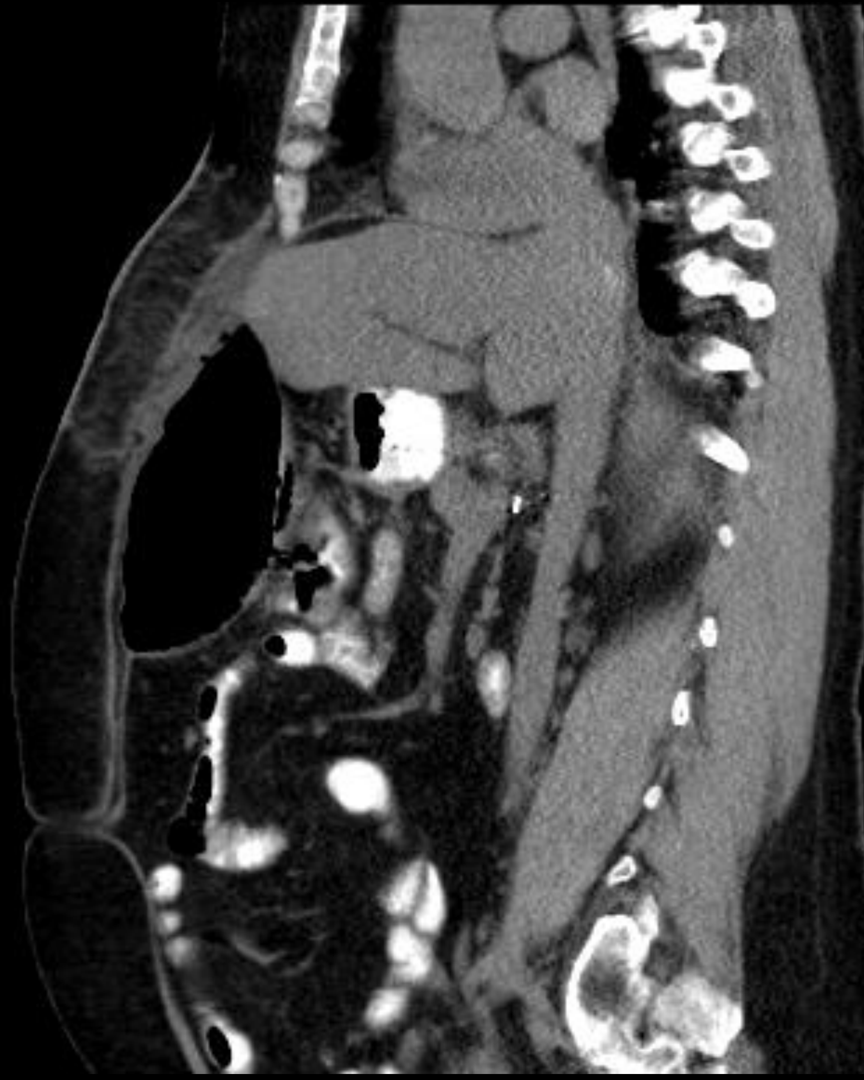


- Where is this air?
- Where did it come from?

GI Perforation



GI Perforation



GI Perforation – Risk Factors

- Instrumentation/surgery
- Trauma (penetrating or blunt)
- Ingestions
  - Medications
    - NSAIDs
    - DMARDs
    - Steroids
    - Antibiotics
    - Immunosuppressive therapies
  - Foreign bodies
    - ingested (chicken or fish bones) or medical devices (e.g. hernia mesh)
- Hernia/volvulus/obstruction -> ischemia
- IBD
- Appendicitis, PUD, diverticulosis->it is, ASCVD, etc

Diagnosis

- Imaging read: "There is a large contained perforation of the transverse colon with 2 separate communicating fistula tracks (series 2, image 40) containing gas, layering stool and a small amount of oral contrast. This measures approximately 12.3 (transverse) by 6.0 (AP) by 9.4 (CC) centimeters."
- Diagnosis: sepsis secondary to perforated transverse colon
- Colonic injury likely occurred during hernia repair 1 week prior
- Delayed systemic response may have been 2/2 immunosuppression

Clinical Course

- Patient urgently consented for exploratory laparotomy for mesh graft removal, colonic injury repair OR possible colonic resection with possibility of diverting colostomy
- On POD 2 from ex-lap partial colon resection with end colostomy with abdominal washout, fever and tachycardia resolved
- D/c home on POD8, 10 day course of abx