

An Unusual Presentation of a Hypermobile Caecum

Kalpesh Patil*, Ali Reza**, Raj Gautam***

Abstract

Hyper mobile caecum is very rarely reported in adults and its occurrence is mostly observed in children. We report a case of hyper mobile caecum in a 22-year-old male, who presented with an acute abdomen. All the cases reported till date presented with volvulus but our case had no volvulus.

Introduction

Hyper mobile caecum is a common surgical problem encountered in paediatric age group, but rarely presents in adults. One case with such intra-operative findings is reported with brief review of world literature.

Case Report

A 22-year-old male presented with acute pain in abdomen in epigastric region with two episodes of vomiting. There was similar history one year back when patient was admitted and treated conservatively. There was no history of chronic constipation, loose motions, bleeding per rectum or any other bowel complaints and urinary complaints. No history of tuberculosis. His general physical examination and systemic examinations were unremarkable. Ultrasonography revealed only dilated bowels filled with gas in left hypochondriac region with atrophic left kidney. X-ray abdomen standing revealed dilated bowel shadow in left hypochondriac region (Fig. 1). Patient was treated on conservative line of treatment initially for first 48 hours of admission suspecting a case of large bowel obstruction. Phosphate enema was given on two occasions without relief. At exploratory laparotomy intra-operative findings were a hyper mobile dilated caecum placed in left upper abdomen with left side atrophic kidney (Figs. 2,3). Two dense fibrous bands were seen obstructing the ascending colon extending from caecum to ascending colon crossing the 2nd part of duodenum (Fig. 4). Bowel Obstruction was relieved

*Post Graduate Student; **Ass. Professor; ***Lecturer; Department of Surgery, M.G.M Medical College, Kamothe, Navi Mumbai.



Fig. 1 : Pre-operative plain X-ray abdomen standing with dilated bowel shadow in left hypochondriac region.



Fig. 2 : Intra-operative dilated caecum placed in left hypochondriac region.



Fig. 3 : Intra-operative dilated caecum delivered outside.

after dividing these bands, prophylactic appendectomy done and caecopexy done in right iliac fossa. Left side kidney was atrophic and right side kidney was compensatory hypertrophied. Post-operative recovery of patient was uneventful.

Discussion

The caecum normally lies in the right lower quadrant of the abdomen. The caecum is derived from embryological mid-gut. During embryologic development the mid-gut temporarily enters the umbilical cord and rotates counter-clockwise about the superior mesenteric artery before re-entering the abdominal cavity. After re-entry the caecum and ascending colon become fixed to retroperitoneum. If this fixation does not occur properly, there is increased mobility of caecum and ascending colon which allows formation of malpositioned caecum and sometimes caecal volvulus.³

In Northwestern university Medical school examinations of 125 cadavers, it was found that approximately 37% of caecum had enough mobility to allow the development of



Fig. 4 : Two thick bands obstructing ascending colon.

a caecal volvulus.^{1,4}

In absence of gangrenous bowel, caecopexy is recommended because of low mortality; low morbidity; low recurrence rate and absence of need to open the unprepped bowel.²

No documentation found in literatures mentioning about the hyper mobile caecum in adult patient in the absence of caecal volvulus.

References

1. Ballantyne GH, Brandner MD, Beart RW Jr, *et al.* Volvulus of the colon. Incidence and mortality. *Ann Surg* 1985; 202 (1) : 83-92.
2. "Caecal volvulus : analysis of 50 patients with long term follow up PMID:453944. *Ann Surg* 1979; 189 (6) :724-31 [PubMed – indexed for MEDLINE].
3. Gamblin TC, Stephens RE Jr, Johnson RK, *et al.* Adult malrotation: a case report and review of the literature. *Curr Surg* 2003; 60(5) : 517-20.
4. Wolfer JA, Beaton LE, Anson BJ. Volvulus of caecum: anatomical factors in its etiology. *Surg Gynecol Obstet* 1942; 74 : 882-94.