



RESEARCH ARTICLE

VISCERAL EMERGENCIES AND PREGNANCY CASE SERIES OF 11 CASES AND LITERATURE REVIEW

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Abstract

Surgical digestive emergencies during pregnancy represent a Situation far from being exceptional, their frequency is of the order of 2/1000 pregnancies. They are dominated by appendicitis, acute cholecystitis, occlusion acute bowel disease and acute pancreatitis. The occurrence of these abdominal surgical emergencies in a pregnant woman Constitutes a challenge for the practitioners concerned because obtaining the correct diagnosis can be difficult due to the normal physiological and anatomical changes that occur during pregnancy. A visceral surgeon cannot therefore envisage the surgical management of a pregnant woman only in a multidisciplinary and joint way, requiring work team between different specialties, and integrating at each stage a gynecologist-obstetrician and the patient. Laparoscopy is a satisfactory option. The action to be taken in the face of these pathologies must be well codified, the first goal being to avoid hypoxia and maternal hypotension, which directly interfere with the fatal prognosis. As a rule, the condition of the mother should always take priority because treatment appropriate from the mother will generally be beneficial to the fetus itself. The maternal-fetal prognosis is linked to the severity of the visceral pathology.

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Introduction:-

Visceral emergencies during pregnancy pose a dual diagnostic and therapeutic problem. The severity of the abdominal pathology as well as the rapidity of diagnosis determine the maternal-fetal prognosis and any diagnostic or therapeutic delay can affect the prognosis.

Materials and Methods:-

Our work is a descriptive retrospective case study about non-traumatic surgical digestive emergencies on pregnancy in the departments of visceral surgery, resuscitation and gynecological-obstetrics at the Mohamed VI university hospital of Oujda over a period of 6-year (from January 2015 to December 2020). Our series contains 11 cases including 3 cases of acute appendicitis, 3 cases of acute pancreatitis, one of which occurred in the postpartum period, 2 cases of acute cholecystitis, 2 cases of cholangitis, and one case of paraganglioma.

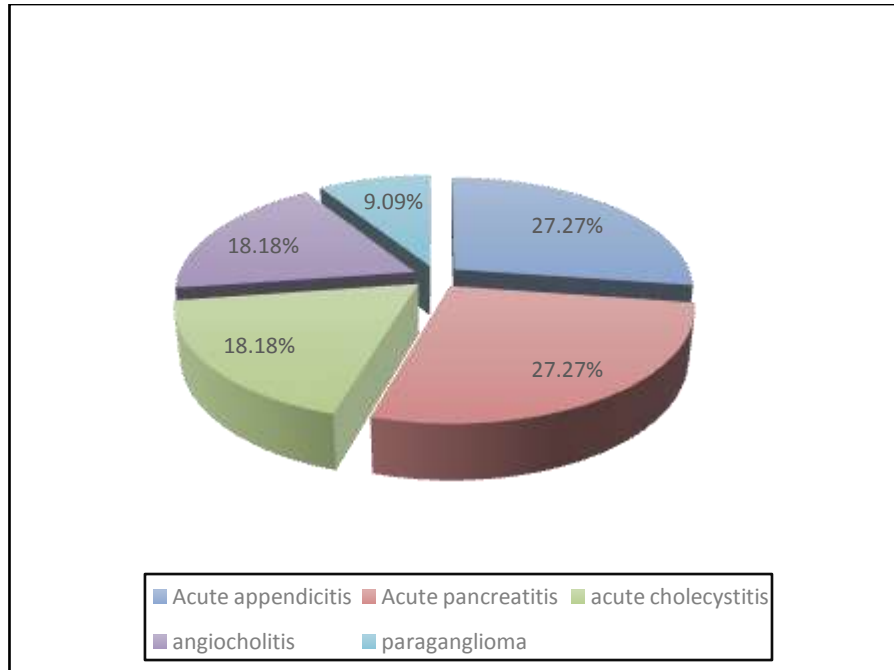
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Results:-

Visceral surgical emergencies occurring during pregnancy is an exceptional event occurring in two pregnancies out of 1000. An entity constitutes a real problem for the concerned practitioners (obstetricians, surgeons, anesthesiologists). The evaluation of pregnant women must take into account the risk-benefit balance of diagnostic and therapeutic methods on the mother and her fetus. The purpose of our work is to highlight the main problems encountered in these major abdominal surgical emergencies, emphasizing the clinical, paraclinical, anesthetic and therapeutic particularities in a pregnant woman as well as the limits and risks of conventional diagnostic tools during pregnancy.

The etiologies were distributed as follow: 3 cases of acute appendicitis (27.27%), 3 cases of acute pancreatitis (27.27%), 2 cases of acute cholecystitis (18.18%), 2 cases of cholangitis (18.18%) and 1 case of paraganglioma (9.09%)



The average age of the cases was 29.63 years; the majority of our patients were in the 2nd and 3rd trimester of pregnancy with a percentage of 45.5% and 27.3% respectively. The most common functional signs were abdominal pain (90.9%) and vomiting (63.6%). The abdominopelvic ultrasound was performed in all our cases (100%), because of its safety and the speed of its realization.

All our patients had an evolving monofetal pregnancy with normal biometry for the given gestational age at the time of diagnosis.

The treatment was surgical in 54.5% of our patients (50% by laparoscopy and 50% by laparotomy). The remaining 45.5% of patients had conservative treatment. The postoperative follow-up was simple in all our patients (100%).

Maternal morbidity was represented by the occurrence of septic shock on acute appendicitis in one of our patients (9%). No maternal mortality was reported in our series; however, a single case of fetal death in utero at 33 weeks was reported in a patient who had a paraganglioma.

Discussion:-

Acute appendicitis is the most common non-obstetrical surgical emergency during pregnancy, it occurs in 1 to 4/2000 pregnancies [1]. Pregnancy does not change the overall incidence of appendicitis, but the severity of this surgical condition may be increased in pregnancy. Appendicitis seems to be more common during the second trimester [4]. Pregnancy does not influence the evolution of acute appendicitis. Thus, the maternal complications of acute appendicitis in a pregnant patient are the same as in non-pregnant women [5]. On the other hand, appendicitis

can have serious fetal complications. No-uira had reported 20% of cases of prematurity, 1 to 8% of fetal death in the event of uncomplicated appendicitis and nearly 20% to 35% in terms of appendicular peritonitis. Fetal bacterial contamination is also common [2]. The treatment of acute appendicitis during pregnancy always comprises a double component, medical and surgical. The efficacy of tocolysis has not been demonstrated [5]. Some authors recommend it from the end of the first trimester to the end of the 34th week of gestation. Antibiotic therapy is always indicated as soon as the diagnosis of appendicitis is strongly raised. It is a broad-spectrum antibiotic therapy, active on BGNs and anaerobes [3]. Surgical treatment can be performed by laparotomy or laparoscopy. In the case of open surgery, the approach depends on the gestational age and the stage of the appendicitis. Thus, in the 1st trimester and at the beginning of the second, the Mac Burney incision is the most used. On the other hand, at the end of the second and during 3rd trimester, the Jalaguier incision is more suitable given the often-high position of the cecum. In case of peritonitis, the median route is indicated [7]. Laparoscopic surgery can be used until the 20th SA It has several advantages: it reduces uterine manipulations, reduces the doses of anesthetic products, reduces the duration of hospitalization and does not modify morbidity [1].

The incidence of acute pancreatitis during pregnancy is variable. It is about 1 per 1000 births. The age of onset does not present any particularities apart from a peak in frequency in the 3rd decade.

Pancreatitis is more common in the 3rd trimester and postpartum. Therapeutic management remains difficult in a pregnant patient with acute pancreatitis. It can be classified into two categories: symptomatic treatment and etiological treatment, essentially of biliary pathology (56% of cases) [9]

An intestinal obstruction rarely complicates the evolution of a pregnancy.

We owe the first observation to HOUSTON in 1830. Its real incidence is not known and varies considerably from one series to another. With a maternal mortality rate according to Redlich is estimated between 6 to 20%

The distribution according to the trimester is as follows: 6% in the 1st trimester, 27% in the 2nd trimester, 44% in the 3rd trimester and 21% during the post-partum. Bridle occlusions are the main etiology [8] the treatment of bridle occlusion in pregnant women is still not codified. In addition, emergency surgery, argues are indicated by the cause-and-effect relationship between the fetal mortality rate and the delay in care, others are wait-and-see because many of these occlusions will regress under medical treatment only. When the term is close or the fetus matures, the induction of childbirth is sometimes an alternative: the sudden decrease in uterine volume allows spontaneous lifting of the obstacle. In case of failure, the surgery is then carried out in a second time with a benefit in terms of survival for the fetus [6]

Conclusion:-

The best way to ensure fetal survival is by ensuring maternal survival, this can be achieved by taking seriously any digestive symptomatology in pregnant women with very precise clinical evaluation and well-directed recourse to paraclinical examinations and finally by adequate and rapid support.

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