

X- SUMMARY AND CONCLUSION

Volvulus is considered a rare form of intestinal obstruction, which results from a twisting of the bowel upon itself. In the earliest stages of volvulus, there may be only obstruction to intestinal continuity, but as the twist persists there will be interference with the blood supply to the involved bowel.

In this essay we reviewed the literature concerning this subject. The incidence was found to be higher in Eastern and African countries than in Western countries especially in elderly men.

It was found that volvulus accounts for about 3-5% of intestinal obstruction and about 10% of colonic causes of obstruction.

Volvulus of nearly all portions of the gut have been observed. Most frequently is the sigmoid followed by the caecum. Transverse colon volvulus found to be exceedingly rare and constitutes less than 4% of all reported colonic torsions.

In infancy volvulus neonatorum occurs as a result of malrotation of the mid-gut, and causes a rare type of mechanical bowel obstruction.

Volvulus of the stomach, small intestine, hepatic and splenic flexures has been reported.

Although the aetiology of volvulus has never been established, yet a number of factors have been reported to predispose to its occurrence such as long mesentery, chronic constipation, a diet high in roughage, mesenteric and other adhesions, and heavy contents of the bowel. Mental patients were found to be more liable to develop volvulus.

Meckel's diverticulum, tumours and pregnancy were found to be co existed with colonic volvulus.

The case may be symptomatic or with no symptoms, and may take either subacute, recurrent or acute fulminating picture.

The patient with volvulus usually presents with a sudden severe abdominal pain followed by abdominal distention. Vomiting may appear early in case of gastric volvulus but later in colonic volvulus where blood passing per rectum may be in small amounts.

As for the diagnosis we found that the confirmatory X-ray films of the abdomen either the flat and erect films alone or even more impressive barium enema, will clinch the diagnosis and differentiate the case from other resembling conditions.

We concluded that neglected or lately seen cases may lead to the most serious complications as gangrene and perforation of the affected bowel with spreading and often fatal peritonitis.

So once the diagnosis has been made, treatment is urgently needed. An attempt should be made for non operative reduction by sigmoidoscope or by rectal tube for sigmoid volvulus and by Ryle tube in case of gastric volvulus which may be successful, otherwise immediate surgical correction is indicated.

The procedure will depend on the viability of the affected segment of bowel. Detorsion with or without fixation will be all that is necessary if the bowel is viable. For volvulus with gangrene an immediate resection either with primary anastomosis or with colostomy is indicated with great risk.

Finally, we can conclude that the early diagnosis and treatment of that cases can avoid the patient the serious complications and lessen the mortality rate.