SCISSORS–Delhi

From the Desk of the President, ASI, Delhi State Chapter

Dr Pawanindra Lal
Executive Director, NBE.
Director Professor of Surgery &
Chairman MAS, MAMC

Dear Colleagues,

I would like to congratulate the editorial team and in particular Dr Sumit Chakravarti, for yet another edition of the Scissors during the period of Covid pandemic. The chapter has continued with the monthly clinical meetings through webinar platform and organised a very successful webinar on the topic "The Emotional and Psychological Impact of Lockdown on Surgeons and Way out" on 27th June,2020, which generated a lot of interest. Dr Nimesh Desai, Director IHBAS, Dr Indu Arneja, Director, Institute of Health Communication and Dr Manish, Consultant Psychiatrist at SGRH were the mental health experts who interacted with Prof Ravi Kant, Director at AIIMS Rishikesh, Dr Adarsh Chaudhary, HOD GI Surgery at Medanta and Dr B Ramana, Consultant Surgeon from Kolkata. The session was moderated by myself and Dr Tarun Mittal.

Your executive has continued to collect donations and support the requirement for various items required by Covid hospitals.

I take this opportunity to congratulate each one of you for the brave fight and continuing to serve our patients despite severe travel and lockdown restrictions.

Your chapter has also made the bid to host the 2020 ASICON. However, in the meeting of the executive committee of the national ASI, it has just been decided to hold the the ASICON 2020 in a virtual format and consider shifting the physical ASICON 2021 to Vishakhapatnam and ASICON 2022 to Mumbai if the GB approves. That would mean that our bid would be applicable now for ASICON 2023.

I would like to place on record our deep condolences to the members of families who lost their dear ones during this pandemic and pray to almighty to grant peace and give their families strength to bear their losses. I would like to condole the demise of our dearest colleague Dr Aseem Gupta, Consultant Anaesthetist from Lok Nayak Hospital who waged a brave battle against COVID but during the phase of making recovery from the chest condition, suffered a severe pulmonary embolism from which he was unable to recover despite best intervention.

As the city seeming to show signs of plateau of cases, I would urge all of you and your families to observe all precautions and advise you against lowering your guard.

Long live ASI Delhi Chapter.

Jai Hind

From the Desk of the Secretary, ASI, Delhi State Chapter

Respected Seniors and Dear Colleagues

Greetings

As we all know humanity is facing an unprecedented situation in the form of Covid 19 pandemic. DSC has been working tirelessly in helping all its members and finding solutions to various problems like shortage of PPEs, N 95 Masks etc for the doctors. These difficult times have tested our resilience as well as given us oppurtunity to innovate. As we all know we were able to resume the academic activities of DSC with great success through online virtual webinars. The monthly meetings are being organized regularly now. The highlights were the webinar organized on the topics of "The emotional and psychological impact of lockdown on surgeons and way out" and "Safe Surgery in this pandemic: practical suggestions/tips".

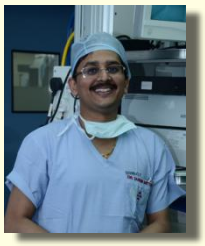
Though the process of Unlock of the country is going on with opening of regular OPDs and starting of elective work and number of active cases of Covid 19 going down in Delhi we still need to be cautious and hold our guards. Hoping that the situation normalizes sooner than later.

Remember

When the going gets tough the tough gets going.

Stay safe.

Long Live DSC ASI



Dr. Tarun Mittal

"Stay strong because things will get better, it may be stormy now but it never rains forever"

From Disruptive Technology to Disruptive Pandemic-Journey of COVID Warrior Surgeon

Minimally invasive technologies disrupted the surgical practices about four decades back. Seemingly a shock for the status quo traditionalist, it came to the diminishing breed of general surgeon as an opportunity to rediscover & redeem itself (1).Our fraternity adopted it enthusiastically & redeemed ourselves from 'Boys with Toys' image to be feted as the smartest amongst our breed (2). Yet our community which prided itself in being the smartest, most 'date worthy', superhuman hero creed as always shown in plays, dramas , novels & movies (3) came face to face with another disruption unleashed by the COVID Pandemic. Corona virus disease 2019 (COVID-19) flattened the geographical, cultural, racial, occupational,and economical barriers, while we continue to try flattening the pandemic curve. The virus is an existential risk, reminding us of our frail individualism & our universal connectedness. It exhorts us to retrospect & introspect for our helplessness despite the prosperity & the technological prowess at our command with. Suddenly we have shed our reluctance to accept our ordinariness & accept the Existential risks posed by developments, such as "Extreme Technology," "Catastrophic Biology-Biodiversity Loss," "Extreme Environments,"& "Advanced Artificial Intelligence" (4).

The professions & economies across the Globe has been decimated. Surgical profession & colleagues having procedure-based practices have suffered the most, amongst medical practitioners.Surgery volumes have continued to decline leading to a devastating effect on incomes & livelihood of surgeons with more than 95% fall in their practice volumes, the hurt being most for most of us who don't do the already declining trauma & transplant surgeries (5).Almost 3 million surgeries have been cancelled worldwide. A Bayesian beta-regression model has shown that > 70% surgeries having been cancelled, of which more than 90% being for benign conditions(6). This is also having impact on 'life saving surgeries' as almost 40% of cancer surgeries & 25% of caesarian sections will be postponed too according to this projection. Pandemic has further restricted us from doing the restricted work because we are sworn to 'Primum non Nocere'. The fear of harming our patients is clear from data that shows that three quarters of preoperatively COVID negative patients are at a risk of developing COVID infection postoperatively, & half of them develop pulmonary complications, of whom almost 40% suffer mortality (6). Suddenly surgeons are looking vulnerable & ordinary, unable to shield themselves, their teams or their patients. It has been three months & the pandemic refuses to flatten, giving us a scare (7).Clinical practice, academics & research have all suffered & need to be started again with a strategic change, may be COVID-19 will help in the required paradigm shift (8). While the paradigm required is vast, technology has come again to our rescue in many ways (9,10). Tele-consultation is one of the changed 'New Normals'.

As clinicians our interaction with our patient follows the seven-step clinical crescendo (11)-

1. Complete structured observation & structured detailed history.
2. Clinical Examination- General physical & system specific.
3. Clinical application of anatomy, physiology, & pathology in context of first two steps
4. Tossing pros & cons mentally & flexing grey matter to postulate a Differential diagnosis.
5. Narrowing the differential diagnosis with Laboratory or imaging investigations.
6. Quasi-invasive investigations e.g. Upper-Lower GI endoscopy etc.
7. Diagnostic-Therapeutic intervention/laparoscopy/biopsy/ surgery etc.

All of these except 2nd & 7th steps can be reasonably accomplished with media base tele-consultation without the need of physical proximity with our patients. COVID pandemic has made people more coversant with technologies like pulse oximeter & various smart phone apps which can give us a fair idea of general physical

examination as well. As a surgeon, I find it easy to examine the inguinoscrotal region including cough impulse, sacrococcygeal region, perineum & perianal regions including a better assessment of anal wink et. al.This was just one aspect of our professional practice. The pandemic will change the way humanity interacts, we being an integral part of this human ocean. We would do well to remember what Richard Selzer said “The surgeon knows all the parts of the brain but he does not know his patient's dreams” & remember that our actions leave scars not only on patient’s body & mind but on ours as well (12). The world war changed the thinking of world from ‘BIG ME’ to ‘little me’, something similar is the undercurrent now. We will do ourselves well to follow the 15 propositions of a life well lived enumerated by David Brooksin his book ‘The Road to Character’(13)-

1. We do not live for happiness; we live for holiness.
2. Proposition one defines the goal of life.
3. Although we are flawed creatures, we are also splendidly endowed.
4. In the struggle against our own weakness, humility is the greatest virtue.
5. Pride is the central vice.
6. Once the necessities for survival are satisfied, the struggle against sin and for virtue is the central drama of life.
7. Character is built in the course of your inner confrontation.
8. The things that lead us astray are short term—lust, fear, vanity, and gluttony. The things we call character endure over the long term—courage, honesty, and humility.
9. No person can achieve self-mastery on his or her own.
10. We are all ultimately saved by grace.
11. Defeating weakness often means quieting the self.
12. Wisdom starts with epistemological modesty.
13. No good life is possible unless it is organized around a vocation.
14. The best leader tries to lead along the grain of human nature rather than go against it.
15. The person who successfully struggles against weakness and sin may or may not become rich and famous, but that person will become mature.

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History of Bladder Stone and The Naming of Prostate.

The history of naming that enigmatic gland at the base of the urinary bladder has an interesting history which is in inextricably entwined with the history of bladder stones.

Humans have endured Urinary Bladder stones since time immemorial. There is evidence of bladder stones in ancient mummies. Bladder stones, scabies and diarrhoea were as common then as present-day ailments like headache, backache or hypertension.

In 16th and 17th century Urinary Bladder stone was a common malady. This gave rise to a curious nomadic trade of Lithotomists or stone cutters, who went around on a horse, village to village removing stones from bladders for a price. The surgery carried a mortality of 40% so these fly-by night 'surgeons' stayed back to collect their fee if the surgery was successful or fled on their quick steads if the surgery went wrong looking for other suffering souls who were found in large numbers in the countryside.

Bladder stones are caused by urinary tract infections which is directly related to lack of hygiene. Normal urine is devoid of any bacteria which once present can cause blood and pus in the bladder, creating a gritty sediment. Repeated bladder infections cause the sediment to become so large that it can no longer be expelled out, resulting in formation of bladder stones. These stones tend to generate repeated waves of infections. With each infection a layer is added to the stone like an onion peel, making it larger.

Why was bladder stones so common in the seventeenth century and so rare today? Houses in Europe were unable to keep the cold and damp away. The people could only protect themselves from cold by wearing thick layers of clothing. Any form of washing or cleaning was difficult as the water was dirty and cold. The water bodies like rivers and canals were polluted with carcass of dead animals, human excreta, cow manure and effluents from industries like tanneries, breweries and smelting. These water bodies were unfit for even washing clothes let alone bathing or drinking. This poor personal hygiene resulted in frequent ascending urinary tract infections which could be in a way prevented by drinking lots of water which itself was scarce. Soups, wine and beer were the best form to consume liquids but this could not be done so by children. [A reason why people in Europe still drink so much beer!!]. Most children acquired urinary tract infections which resulted in stones which had a lot of time to grow till adulthood.

Bladder stones made every act of micturition a torture with burning pain, bleeding and a crazy urge to pass urine all the time with no respite. So excruciating were the symptoms of bladder stones that ancient torturers tied up the penis of their victims to produce in similar symptoms. This constant torture made the patient desperate to get rid of the stone notwithstanding the pain and nearly 40% mortality associated with its surgery.

Those afflicted with this, knew exactly where to reach to get the stone out- the perineum and so did the stone cutters. Reaching the urinary bladder from above was fraught with danger as it had to be done through the abdomen where there was danger of damaging the intestines and resulting death. This access route had always been taboo because of a warning by Hippocrates, who believed that a wound on the upper side of the bladder would always be fatal.

With the perineal approach, there was danger to the blood vessels and various sphincters of the anal canal and urinary bladder. The stone cutters had no clue of the anatomy but knew that the easiest way to remove the stone was through the perineum. Indeed most patients who survived the brutality of stone cutters were left with a wound that would fester for years and were finally incontinent to urine and stool.

There was another way to extract the stone and this was through the urethra which was dubbed Apparatus Major as many instruments were required. (The perineal approach was called Apparatus Minor as minimal instruments were required)

The ‘minor’ operation (using the ‘apparatus minor’) was described in the first century AD by the great Roman apothecary Celsus, but had already been applied for many centuries. The principle of the ‘minor’ operation was simple. The patient lay on his back with both legs in the air called the lithotomy (litho- stone; -tomy - removal) position. (A position still used in modern surgeries). The stone-cutter then stuck his index finger into the patient’s anus pulling and steadying the stone in the perineum. He then asked someone to hold the scrotum away from the operative field, while an incision was made between the scrotum and the anus. The patient was asked to bear down as in child birth. Another person helped by pressing on the abdomen while the stone-cutter pulled the stone out with a hook. If successful, bleeding was stopped by applying considerable pressure to the wound for as long as possible. As the approach to the bladder was from the back, this surgery could be performed in men up to 40 years of age. Around that age, a gland swelled up and got in the way of the incision. This gland was hence called prostate; got from the word prostrate meaning 'lie in front'.

The ‘major’ operation was also called The ‘Marian operation’ after the person who first described it in 1522. The ‘major’ operation too was conducted in the lithotomy position, but the scrotum did not need to be lifted out of the way. A bent rod was inserted into the bladder through the penis and a vertical incision was made in the direction of the rod, between the penis and the scrotum, along the centre line of the perineum. A ‘gorget’, a grooved instrument, was then inserted into the bladder, through which the stone could be crushed and removed in fragments, using spreaders, forceps and hooks. The advantage of the ‘major’ operation was that the wound was actually smaller, reducing the risk of incontinence.

For anyone who is still curious about how a lithotomy must have felt, the French composer Marin Marais set the ‘major’ operation he had himself endured in 1725 to music. The piece, for viola da gamba in E minor, is called ‘Tableau de l’opération de la taille’. It lasts three minutes and describes the operation’s fourteen stages from the perspective of the patient: the sight of the instruments, the fear, bracing oneself and approaching the operating table, climbing onto the table, climbing off again, reconsidering the operation, allowing yourself to be tied to the table, the incision, the introduction of the forceps, the extraction of the stone, almost losing your voice, the blood flowing, being released from the table and taken to bed. Prevention was of course the best treatment for this malady. The availability of clean drinking water together with increased awareness of personal hygiene like clean underwear has done more in combating this great tormentor of mankind than any new operating method.

As a consequence, genuine lithotomies are rarely performed now, and never via the perineum. Furthermore, the operation is no longer the domain of the surgeon, but the urologist. However, the gland lying prostrate between the bladder stone and rectum remains the same – THE PROSTATE!!

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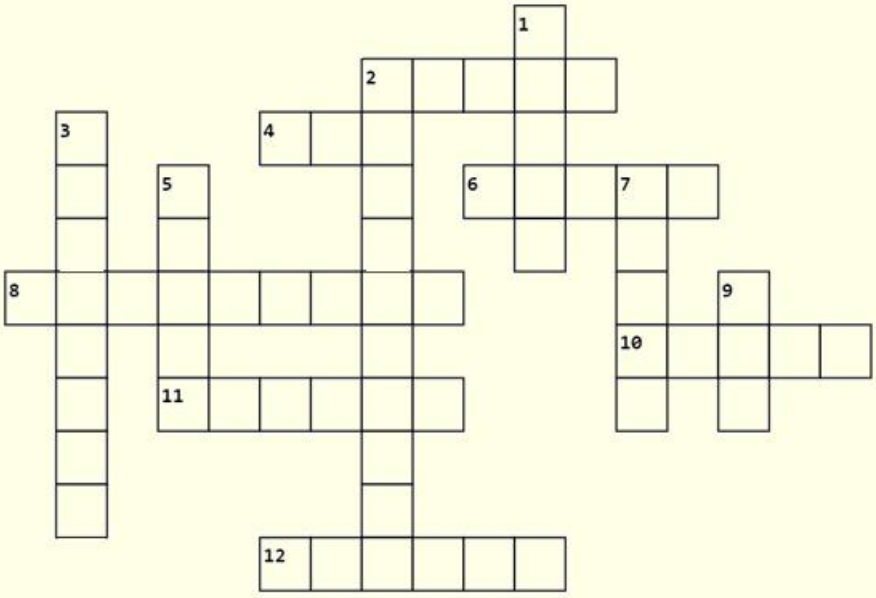
COVID CROSSWORD



Across

1. **2.** the organism that causes some diseases
2. **4.** personal protective equipment
3. **6.** the vaccine expert
4. **8.** lung infection
5. **10.** the country most affected
6. **11.** the protective suits
7. **12.** virus causing the current pandemic

Down

1. **1.** the city from which it originated
2. **2.** the machine that supports breathing
3. **3.** caused by animal contact
4. **5.** the main symptom
5. **7.** acronym for the disease
6. **9.** the animal thought to be the initial carrier

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 # For answers visit the last page

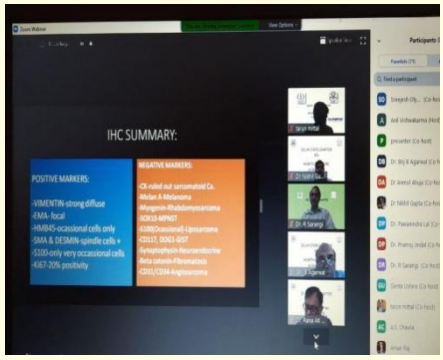
Chapter Activities

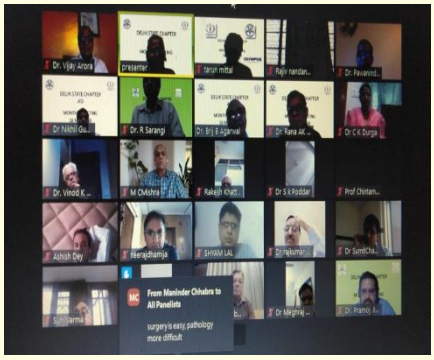
The monthly meetings of Delhi State Chapter from March 2020 were postponed due to this pandemic situation.

The Delhi State Chapter and SGRH in association with M/s Olympus hosted this clinical meeting on 16th May 2020.

The cases were as follows: -

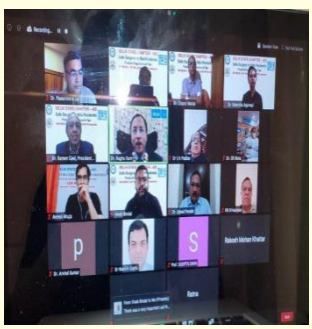
1. Laparoscopic approach to Aldosterone Producing Adenoma -;a rare case - Unit 1A- Dr. R Sarangi & Dr. M Gupta
2. Unusual case of lump abdomen presenting as dysuria- Unit IB – Dr Brij B Agarwal & Dr. N Dhamija
3. Combined tracheoesophageal transection: Infrequent but menacing- Unit II - Dr. V Arora, Dr. C S Ramachandran, Dr. P Jindal, Dr S K Das
4. Proliferative fasciitis- A rare entity- Unit III- Dr. V K Malik, Dr. T Mustafa, Dr. T Mittal, Dr A Dey





Delhi State Chapter organized a LIVE Webinar on "Safe Surgery in this Pandemic: Practical Suggestions/Tips" on May 30, 2020.

Approx 120 delegates participated in this webinar



Chapter Activities

The April monthly meeting of MAMC was held on 13th June 2020

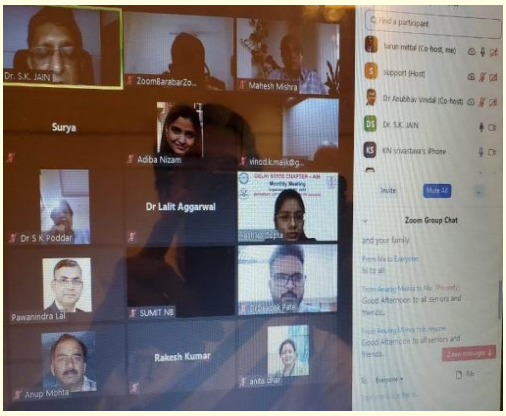
The cases were as follows: -

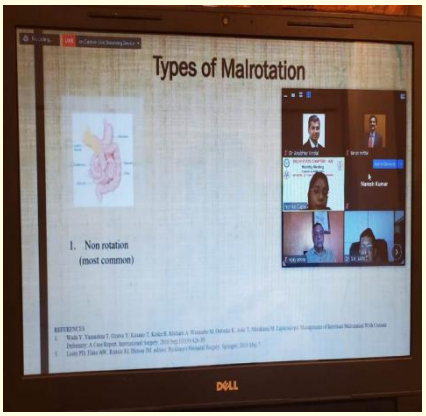
1) Loops in knots - a diagnostic enigma - Dr Pawanindra Lal's Unit

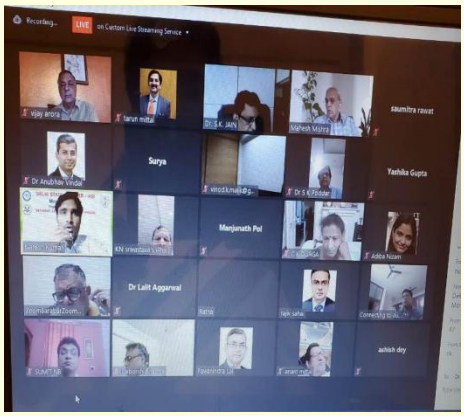
2) Giant Angiomyolipoma masquerading as perinephric abscess- A diagnostic conundrum - Dr SK Jain's Unit

3) A Rare case of neuroendocrine tumor of stomach - Dr CB Singh's Unit

4) An interesting presentation of intestinal obstruction - Dr Sushanto Neogi's Unit





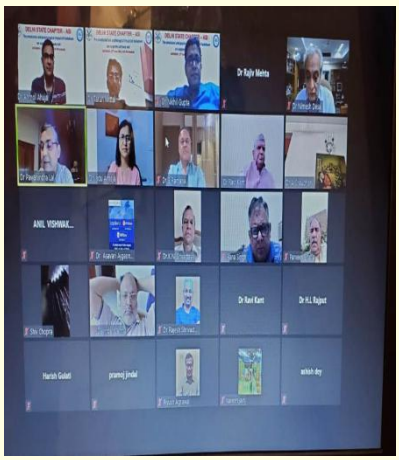


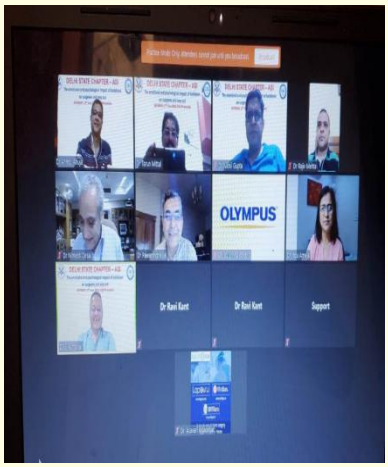
Delhi State Chapter organized a Webinar on

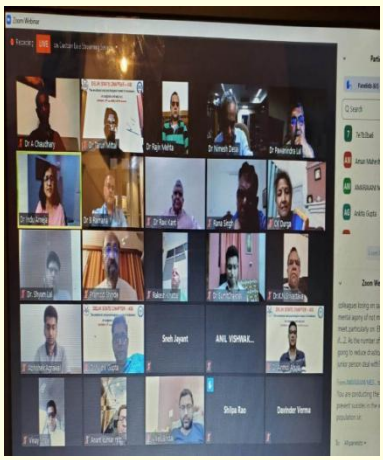
"The Emotional and Psychological Impact of Lockdown on Surgeons and Way out"

on June 27, 2020

Approx 120 delegates participated in this webinar







Chapter Activities

The Delhi State Chapter in association with Deptt. Of Surgery, Hindu Rao Hospital & North DMC Medical College hosted the PG Masterclass and clinical meeting on 11 July 2020

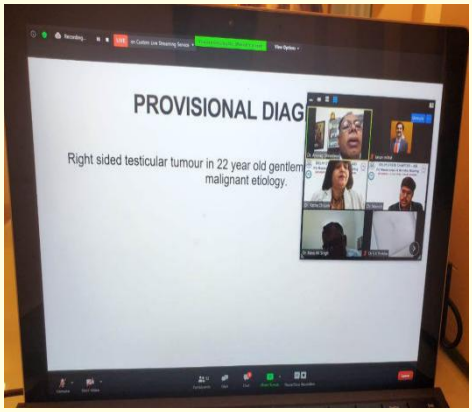
PG Master class

Case I - Swelling in the parotid area

Case II- Scrotal swelling

Monthly meet . The cases were as follows:

1. Gastric Volvulus
2. Managing large abdominal defect after tumor excision
3. Pseudoascites
4. Yin-Yang Flap



COMMENDATION

Editorial Board, on behalf of members of Delhi State Chapter congratulate our Past President, Dr. Brij B. Agarwal for being given the responsibility of The Editor-in-Chief of Indian Journal of Colorectal Surgery (IJCRS). IJCRS is the official journal of The association of Colon & Rectal Surgeons of India (ACRSI). ACRSI is a section of ASI.

The IJCRS Journal can be accessed free online at- http://www.ijcrsonweb.org

Please contribute with your letters or articles under different categories. Please ask your residents to submit case reports to start with.

Saving Mr. Raees

Dr. Aditya Rajpal

Surgery Resident

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Most days are ordinary and they leave no everlasting impression on one's mind.26th August 2018 was different. We had a 50 something year old patient in our general ward. He goes by the name of Raees, a word which in Hindustani means rich. And yet the tragedy of his suffering was that his very stay in our rather modest setting of a hospital had cost him to the extent that at least in terms of money, he had none left. Raees was, to put it mildly, bankrupted by his disease. A month and a half ago, he had undergone laparoscopic appendicectomy at an outside hospital. He had been discharged in a stable condition and was doing fine till the 5th post operative day, when all hell broke loose. His abdomen became distended, his pulse feeble and he was brought to our hospital in a dire state. In a matter of a few hours, he was operated upon and intubated and shifted to the ICU. For those who spend their days in and around the hospital, it is common knowledge that an intubated patient in there has only two ways, and most of it is dependent not on what is done to the patient but how the patient responds to what is done. We may say a lot of things to the patient, but we know it in our hearts: The ICU is bleak, dark and dismal place in the hospital and things only need to change slightly in one direction or the other for the patient to make it or break it. Raees stayed in the ICU long enough to require a tracheostomy, a tube that bypasses the upper respiratory tract thereby bypassing major foci of infection. Nonetheless, our old man had fever and continuously so. A look at his abdominal wound and we knew what was wrong. His surgical wound had become infected. Not surprising considering he had cecal gangrene and that he had required a colostomy in view of heavily contaminated abdominal contents. So I opened up his sutures to drain whatever was of that infected collection. All seemed fine. Until the next morning. I decided to go early morning at around 4:30 to make sure his wound was okay. Lo and behold, his wound smelled of fecal matter. I called my senior registrar. He had a look at the wound and frowned subtly. What it meant is that a part of his intestine had given way and what should ideally be coming out of his colostomy was now spreading all over his abdomen, and Escherichia coli in his stool would have no qualms about poisoning everything in its path. From here on, his journey could go two ways. Either he would make it, with a heavily scarred abdomen, a poor respiratory system and no money, or he would die, not suddenly, but slowly. Over the course of the next few days, his organ systems would shut down, he would spike fever and continuously so. His body salts would go into disarray and so would he, mentally. It would be a long, long struggle for his family to see him go, part by part, organ system by organ system. Bearing in mind that his age, his diabetes and his general body habitus, we did not have a good feeling about this. But science or surgery don't work on feelings, they work against them, against intuition. Much of what we do is to gain ground, even if it is just by a tiny, miniscule margin, and as time goes by, the small margin becomes big enough to count. And so it was with him and us.

His relatives were counseled to be prepared for a long, arduous and drawn out battle. Progress may or may not come, and even if it did, two forward steps could be followed by three backward steps and so on. They consented and we prepped too. A sump was installed, to drain out whatever could be from his midline wound. The sump is a time consuming dressing wherein a drain is placed in the midline and connected to a suction. It would be changed once daily, sometimes twice. Each day the output would be measured and compared to the colostomy output. It was a tug of war between the two outputs. If the sump output won over the colostomy output, we would lose. Otherwise, we may win. Fortune finally favoured us and the sump output reduced, not significantly but enough to tell us that things were okay. Along side we had hoped the fever would subside too but it didn't. And as he complained of pain in his abdomen we knew the battle was far from won. Cultures were sent, blood, urine, sputum, endotracheal suction, midline wound. And antibiotics were added accordingly. The fever refused to budge nonetheless. And ultrasound and CT scan later, it came to our notice that he had a liver abscess. A pig tail drain was inserted, removed and then re-inserted. 40 days post his second surgery, his fever spikes began to drop. Soon after, his tracheostomy tube was pulled out and he was made to talk. It was 9 am and the sun was out. Like all days. But it was no ordinary day. Our consultant went "Raees, your tube is out, try saying something, just your name perhaps". That's when he said, "R… Ra..Raees". The word that came out of his mouth sent a jolt of shock through my body. It was a revelation, a second birth. This man had been brought back from the death, not once but twice and to hear him talk after having seen him in a state of sedation at first, in sleep later, and then the use of hand gestures was surely enough to make me cry. And I did. But I wiped them off before anyone could see them.

This man had spent all his savings on his life, and his family had staked their fortune on the words of a few young doctors telling them to keep faith and watch. We had spent tons of money on his antibiotics, and some of us would have backache issues later on in life from all the bending down and dressing the wound on him and other patients. Nurses had listened to his every beck and call. We had spent hours agonizing over little details, wondering as to why he had fever, why his stoma behaved a certain way. His outputs, his drugs, his vitals charts had all been looked at, argued upon and made their way into our management. Economists would say that the combined human resource and monetary requirement in his case had been ludicrous, and some may even call it a waste. But for me, 26th August 2018 is a day that will remain etched in my memory as the day when I noticed the second birth of an old man, and this will stay for as long as I don't have dementia and after that perhaps, no one will recall what was done and how a life was saved by sheer grit of a man and his medical team. But for the here and now, this should suffice and as I travel home in the metro, tired and sleep deprived, being stared at by this weird old lady sitting next to me, a gentle smile on my face is thanks to our man, Raees and to the grace of the almighty who made us capable of serving him by serving Raees and I guess, for now, this sure does suffice!

MULTIPLE JEJUNAL DIVERTICULA: A RARE CAUSE OF INTESTINAL OBSTRUCTION

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INTRODUCTION

Diverticular disease of the small bowel is relatively uncommon condition amongst the various different pathologies seen in small bowel. Small bowel diverticulosis was first described in 1794 by Baillie and Von Soemmerring whereas jejunal diverticulosis was first described in 1807 by Cooper.[1] Mostly these diverticula are asymptomatic and are discovered incidentally[2] during workup for different conditions. When symptomatic, the symptoms can be varied ranging from non-specific presentations like abdominal pain, nausea/vomiting, diarrhea and mal-absorption to more acute complicated presentations like diverticulitis, gastrointestinal (GI) haemorrhage, intestinal obstruction and perforation.[3] As such early diagnosis is difficult and mostly the condition is diagnosed once the complications occur. We report a case of jejunal diverticulosis presenting as acute intestinal obstruction.

CASE REPORT

A 70 year old female was brought to surgical casualty with complaint of pain abdomen, vomiting and not able to pass stool and flatus for last 5 days. She was dehydrated and abdomen was distended with bowel sounds present. Laboratory investigations were slightly deranged with leukocytosis and raised urea and creatinine. X ray abdomen showed dilated bowel loops and multiple air fluid levels. Diagnosis of acute intestinal obstruction was made and exploratory laparotomy was done. Intra-operatively multiple large diverticula were seen in jejunum with a band was seen causing obstruction in the right iliac fossa. The band was running from the distal most diverticula to the right lateral abdominal wall/peritoneum (as seen in Images). The band was cut and resection anastomosis (end to end) was done. Patient was discharged after drain removal on POD 10. After follow up of 2 years patient is doing well.

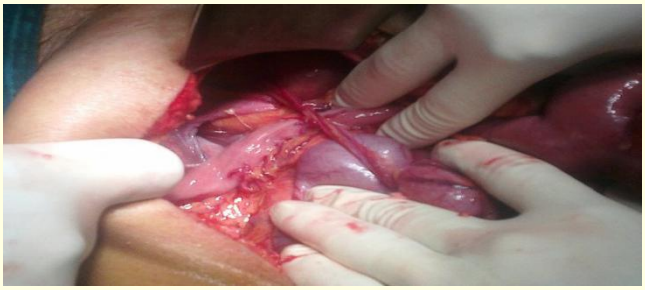

Image 1 – Showing Band from the diverticula to abdominal wall causing obstruction

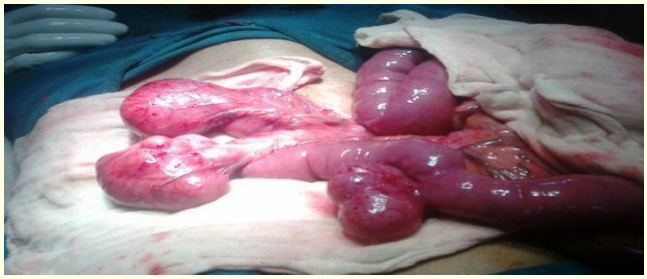

Image 2 – Showing multiple large diverticula from the jejunum

DISCUSSION

Small bowel diverticula are rare, with the prevalence at autopsies ranging from 0.6–1.5%, and incidence on imaging 0.002–0.7% as reported in the literature.[4,5] In the small bowel, duodenum is the most common site of diverticulosis followed by the jejunum with diverticulosis being least common in ileum due to the greater diameter of penetrating jejunal artery than the vessels supplying the ileum.[6]

The etiology is unclear. However, it is mainly thought to be due to abnormalities of the smooth muscles or of the myenteric plexus resulting in intestinal dyskinesia with the diverticuli occurring at the site of entry of the jejunal arteries into the jejunal wall.[7] These factors appear to be important considering the low pressure of the jejunal contents. Acute complications of jejunal diverticulosis include diverticulitis, perforation, haemorrhage, and intestinal obstruction.

Acute diverticulitis is quite uncommon with a reported frequency of 2.3%. Acute jejunoileal diverticulitis can be treated non-operatively in the absence of sepsis and peritonitis. Antibiotics, fluid resuscitation and bowel rest lead to improvement in symptoms in 75 percent of patients.[8] Laparotomy is usually reserved for those patients who have associated perforation and/or obstruction.

Mechanical obstruction in patients with diverticulosis has a reported incidence of approximately 2.3%- 4.6%.[9] Causes include adhesion band formation due to inflammation, extrinsic compression from an adjoining bowel loop with large diverticulum or intussusception.[10] As in our case, an adhesion band was present which was most likely formed after an inflammatory episode involving the diverticulum.

In cases of complicated jejunal diverticulosis, plain abdominal X-ray films may demonstrate distension of small bowel, air-fluid levels and pneumo-peritoneum. Barium follow-through study and enteroclysis are more specific although their utility is limited in emergency setting.[11] Computed tomography findings of diverticulosis are focal areas of out-pouching of the mesenteric side of the bowel, localized intestinal wall thickening due to inflammation or edema, abscesses, free abdominal fluids and pneumoperitoneum. Multi-slice CT appears more specific than enteroclysis in diagnosing diverticulosis.[12] However, in case of emergent presentation, many times there is not enough time for a detailed radiological work up and patient may have to be operated early.

CONCLUSION

In conclusion, jejunal diverticulosis is a rare condition and difficult to diagnose which can lead to many patients being treated only once the complications set in. Most of the patients are old with several co-morbidities and have long standing symptoms of chronic abdominal pain or mal-absorption which are often neglected by the clinicians. Since the spectrum of complications is wide and potentially life threatening, a high index of suspicion is needed. A radiological evaluation is warranted if there is a suspicion of this condition so that adequate treatment is initiated before the complications set in.

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Editor's View

Dear Seniors and colleagues,

It Is an honour to contribute as an editor of " SCISSORS" and present the achievements and the activities of the best state chapter of Association of Surgeons of India. It is the surgeon's duty to tranquillize the temper, to beget cheerfulness, and to impart confidence of recovery. Newsletter is a medium through which we can express ourselves. I request all my colleagues to speak up their mind and actively contribute to the Newsletter. Looking forward for your support and guidance.

"Unity Is strength… when there is teamwork and collaboration, wonderful things can be achieved"

With regards

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Answers to COVID CROSSWORD:

Across

1. 2. the organism that causes some diseases - **virus**
2. 4. personal protective equipment- **ppe**
3. 6. the vaccine expert- **fauci**
4. 8. lung infection- **pneumonia**
5. 10. the country most affected- **italy**
6. 11. the protective suits- **hazmat**
7. 12. virus causing the current pandemic- **corona**

Down

1. 1. the city from which it originated- **wuhan**
2. 2. the machine that supports breathing- **ventilator**
3. 3. caused by animal contact- **zoonosis**
4. 5. the main symptom- **cough**
5. 7. acronym for the disease- **Covid**
6. 9. the animal thought to be the initial carrier- **bat**