

Midgut volvulus: Rare presentation of Acute Abdomen in Late Pregnancy: A Case Report

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Objective

Abdominal pain is a common symptom during pregnancy, but bowel obstruction as the cause is a rare phenomenon. The aim is to discuss the diagnostic challenges, management, and surgical outcomes in a complex obstetric and gastrointestinal context. Multidisciplinary approach to make prompt, accurate diagnoses and timely intervention can prevent fatal outcomes.

Discussion

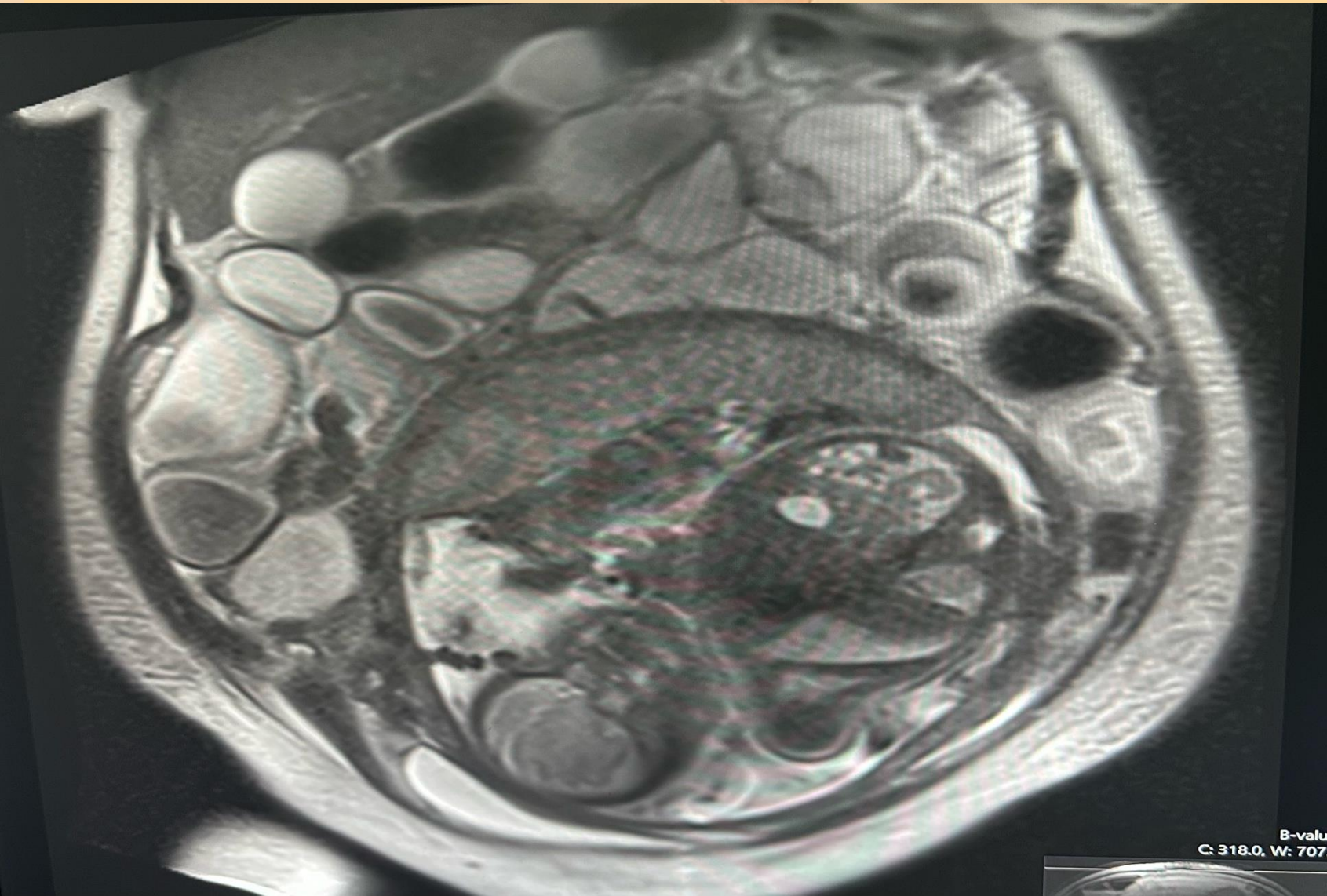
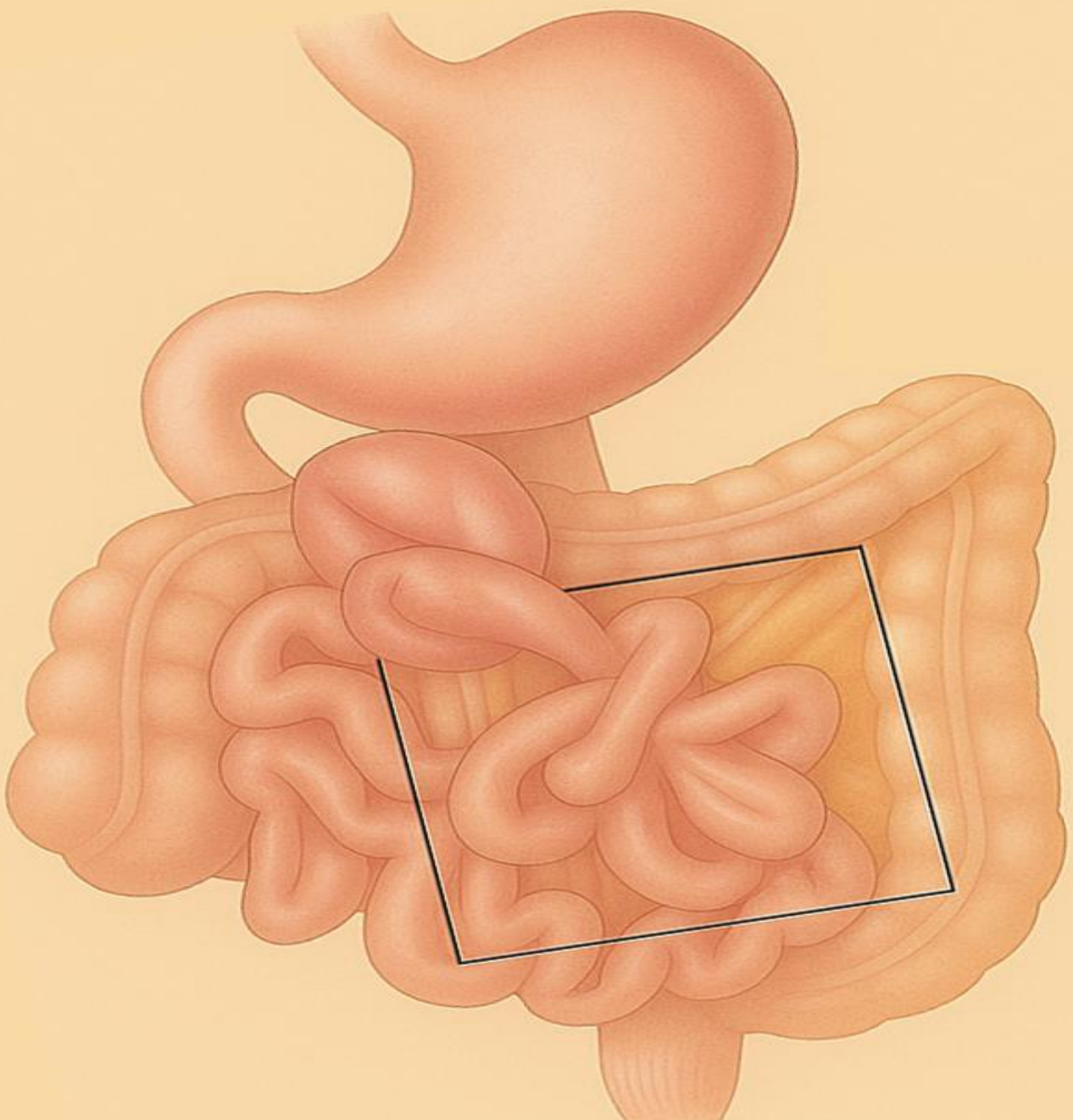
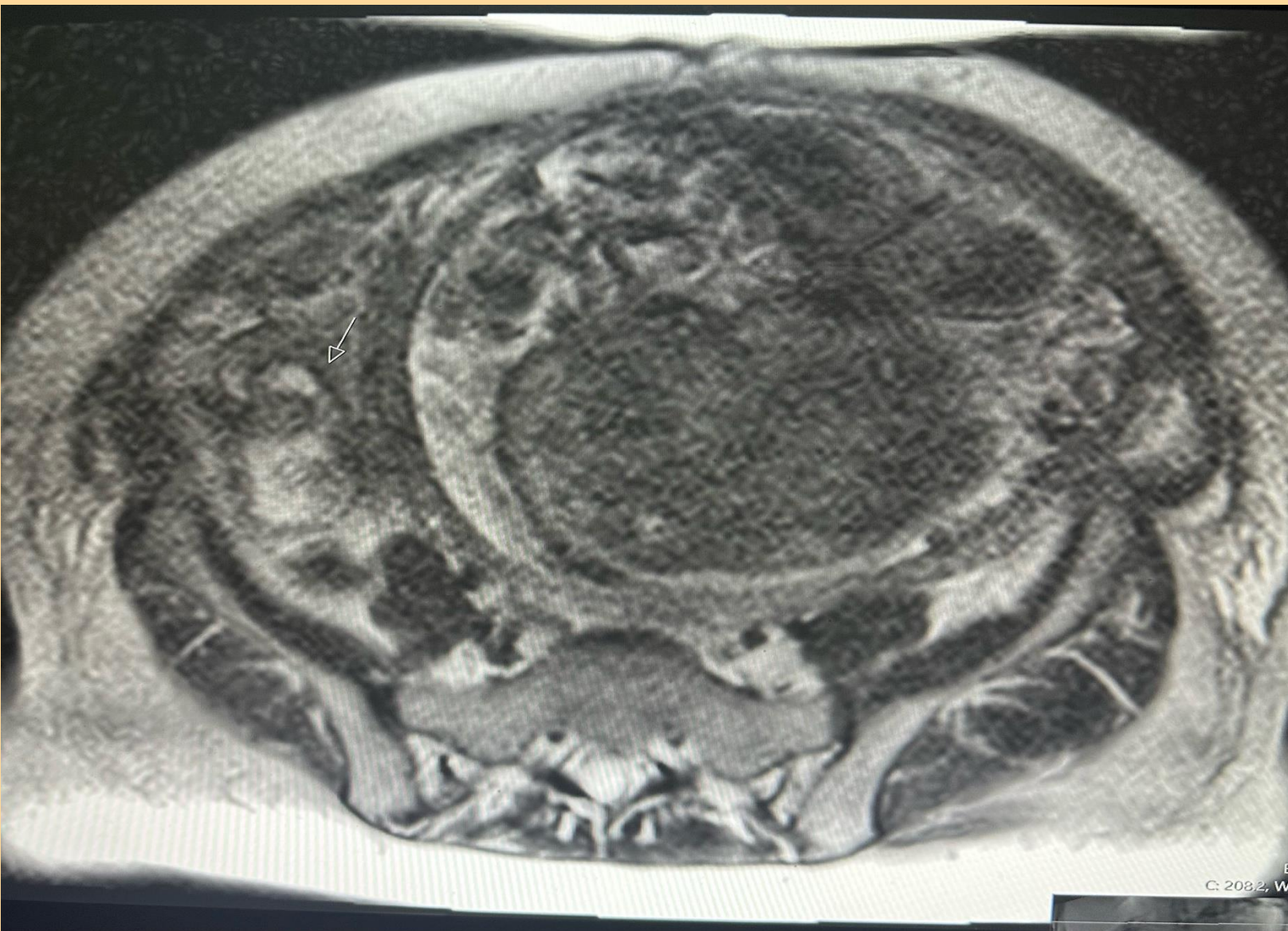
Bowel obstruction is an infrequent cause of abdominal pain in pregnancy, with an incidence of 1 in 10,000.¹ The most common etiology of small bowel obstruction during pregnancy is because of adhesions, making up approximately 50%–60% of all cases. Midgut volvulus represents approximately 25% of all intestinal volvulus, but in pregnancy, only makes up 1%–3% of all cases.

Conclusion

Volvulus in pregnancy can be extremely dangerous not only because of its similarity to other causes of abdominal pain but also because of physician hesitancy to proceed with radiographic imaging, ultimately delaying diagnosis which could be fatal. This case highlights the need for a timely, multidisciplinary approach to ensure coordinated decision-making across specialties.

Case Report

A 35-year-old woman, P1 at 32 weeks gestation, presented to triage twice within 24 hours with worsening upper abdominal pain, nausea, and vomiting. Her history included a cesarean section (2022) and childhood appendectomy. On examination epigastric tenderness was noted and the rest of the observations were normal, and the cervix was closed. Initial management involved IV fluids, analgesics, and antiemetics, with a working diagnosis of gastritis, biliary colic, or pancreatitis. She had a recent growth scan on the 95th centile. Her investigations showed: Rising ALT (47→218), WBC initially elevated (11.9→8.6), CRP peaking at 48 mg/L, Hb dropping (120→98). Extensive investigations by the gastroenterology and medical teams showed normal Alpha-1 Antitrypsin, bilirubin, bile acids, clotting profile, immunoglobulins, and ceruloplasmin. Viral serology and liver autoantibodies were negative, and the abdominal scan was grossly normal. The patient’s symptoms progressed to severe abdominal pain, bilious vomiting, and distension, with absent bowel sounds and ketonuria (+4). The patient reported a ruptured appendix at age 7, followed by bowel obstruction from adhesions requiring surgery, possibly bowel resection, with no records available. She has had no bowel issues since. MRI revealed small bowel obstruction with terminal ileum volvulus, likely secondary to adhesions. Transferred to the surgical ward for further management, there was no response, despite gastrografen trials twice and NG aspiration. She received two doses of antenatal steroids and 4 hours of magnesium sulfate preoperatively, with neonatology review completed. An emergency laparotomy and cesarean section were performed via a midline incision, delivering a cephalic baby in good condition. Postnatal LMWH was prescribed for 6 weeks. Surgical findings revealed distal ileum adhesion forming a window for an internal hernia, causing twisted small bowel obstruction. The hernia was reduced, a serosal tear repaired with 3-0 PDS sutures, and small bowel viability confirmed after adhesiolysis. Postoperatively the patient maintained TPN, strict fluid balance, and IV antibiotics were continued. Pain management, with antiemetics as needed. The catheter was removed, and the diet was gradually reintroduced under dietician guidance, and TPN weaned off. The patient was discharged on day 8 post op with uneventful recovery.



References:

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