A Case Report

Sclerosing Peritonitis

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ABSTRACT
We have already reported four cases of sclerosing peritonitis in 2001[1]. This is a further reporting of two more cases of this rare syndrome treated by the authors in last two years. One had measles 10 days before her symptoms, other was taking anti tuberculosis drug for carries spine. We believe that none of above reason i.e. measles and A.T.T could be the cause of sclerosing peritonitis in these two cases and they were just co incidental.
Keywords: Sclerosing Peritonitis

INTRODUCTION

Sclerosing Peritonitis is a rare disease where small intestinal loops are encased in a fibro collagen membrane like a cocoon. It was first reported by Owtschinni kow in 1907 [2]. It is also called Idiopathic sclerosing peritonitis or sclerosing encapsulating peritonitis (SEP) or abdominal cocoon or peritonitis fibrosis syndrome [3]. Its aetilogy is not known. It is postulated that any thing which constantly causes irritation of peritoneal cavity can cause SEP [4]. Example is peritoneal dialyzing fluid following CAPD [5,6], following peritoneovenous shunt for ascitis [7, 8]. Foo postulated that this disease commonly occurs in young adolescent females from tropical or subtropical countries, it may be due to retrograde menstruation with a superimposed viral infection [9]. Narayanan hypothesis that it may be due to retrograde gynaecological infection [10]. However the above theories have been negated by the fact that this disease has also been reported in males, premenopausal female and children [11,12,2]. However tuberculosis [1,13,14] and sarcoidosis [15] and proctalol a beta-blocker [16] has been reported to be the cause of few cases.

It presents in form of recurrent episodes of acute sub acute or chronic small intestinal obstruction or just ill health, nausea, vomiting and an abdominal mass [6] even in some cases without any symptoms [12]. So many investigations like Ba meal, [17] US [5] CT scan [18] Pet [19] have been described for its diagnosis but most of the cases are diagnosed incidentally at laparatomy.

As far as treatment is concerned Celicout has suggested no surgical treatment for asymptomatic cases [20]. Junor suggested immunosuppressant drugs for this disease [21], but surgery is treatment of choice i.e careful dissect and excision of thick sac and dense interbowel adhesions with the release of small intestines [22].

Case 1:

Sadia 20 years presented on 25-07-08 with pain and swelling lower part of abdomen, vomiting and fever since 2 days. She also had pain in fingers, wrists, joints and back. There was no constipations. There was no problem with urination or menstruation. Once she had pain lower part of abdomen 8 years back which was treated conservatively. She also got measles 10 days before. There was no history of any operation or trauma in the past. On examination she was a fit weakly built young woman, pulse 80/- BP 130/70mm, Temperature 99^{o}F. Abdomen palpation revealed central abdominal lump,fixed and tender on deep palpation.

Blood Examination: HB 10.7G, TLC 11500, ESR 26, Blood Group B+.

X-ray abdomen: Two insignificant air fluid levels in the pelvic area.

Ultrasound: clumped dilated loops of intestinal with out peristalsis.

Operation: She was operated after proper preparation and hydration. She was opened by midlines incision under G.A. All small intestine were cocooned upto the base of mesentery. Sigmoid and transverse colon were free. Removal of tough membrane and release of the intestine was done. Cefotoxime and metronidazole were given as prophylactic antibiotic and one unit blood was transfused. She made an uneventful

recovery and was discharged after 9 days when stitches were removed and healing was perfect. She attended the surgical out door after 7 days and had no complaint. Biopsy report was reactive lymph gland hyperplasia.

Case 2:

Sidra 12 years old female belongs to a very poor family presented to us on 15-05-09 with nausea vomiting, pain abdomen since one month but worst since 2 days. She also had constipation since 7 days which was relieved after enema. She has been taking anti tuberculosis treatment for TB spines since one month. There was no past history of any trauma treatment or operation. Her urination and menstruation was normal. On examination she was week and undernourished girl. Pulse 80/ minute, BP 90/60, temp. 98.8^{o}F. There was a defused central abdomen lump which was fixed, firm and non tender.

Blood Examination: HB 13.9, blood group O+, ESR 28 per hour.

Ultrasound: Gut looked dilated, sluggish peristalsis were found. There was a free fluid in peritoneum. Ba Enema was normal.

Operation: she was operated on 17-05-09 abdomen was opened by midlines incision. There was cocooning of whole small intestine upto the root of mesentery. Sigmoid and transverse colon were not involved.

Release of all the loops of intestine was done after removal of encasing tough membrane. She made an uneventful recovery was discharged on 9th postoperative day after removal of sutures. She reported 7 days after in OPD with no complaint.

Biopsy Report: Reactive hyperplasia of lumph gland.

DISCUSSION

SEP is a rare cause of obstruction but not very rare. We have already reported 4 cases in the past and dealt with two more present cases tu et al in 2006 reported 203 cases of sclerosing peritonitis in the Chinese Medical literature [23].

When a case of acute or subacute or chronic intestinal obstruction present, with central abdominal non tender, defused, fixed mass in young females think of this rare disease. Surgical treatment is not difficult provided one is careful and patient to take his time to remove the whole covering membrane. Results are really rewarding. Resection of the intestine is unnecessary and is reserved for non viable bowel, as it carries high morbidity and mortality [22]. We always take mesenteric gland for biopsy in case it may be due to tuberculosis which needs treatment post operatively.

In our both cases diagnosis of SEP was incidental at laparotomy. Measles in first case and ATT in second case was just co incidence as biopsy was proved negative and second patient continued anti tuberculosis drugs with no recurrence. Both made uneventful recovery following the classical surgery.

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