CASE REPORT

ISOLATED CASE OF CHILAIDITI SYNDROME

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ABSTRACT

Chilaiditi syndrome is a rare condition when pain occurs due to transposition of a loop of large intestine in between the diaphragm and the liver, visible on plain abdominal X-ray or chest X-ray. Such case can be without any symptoms or can be presented with abdominal pain, vomiting, anorexia, constipation, flatulence or air swallowing. Patient has feeling of pressure in upper abdomen when upright.

The occurrence (incidence) of it on abdominal or chest X-rays is around 0.1% but it can be up to 1% in series of older adults. It has also been reported in children. During our clinical practice we encounter a interesting case of Chilaiditi syndrome. Here we are presenting a case of 18 yr old male patient who developed chilaiditi syndrome with mild symptoms and signs of sub acute intestinal obstruction.

Key Words: Free gas under diaphragm, chilaiditi syndrome, bowel perforation.

INTRODUCTION

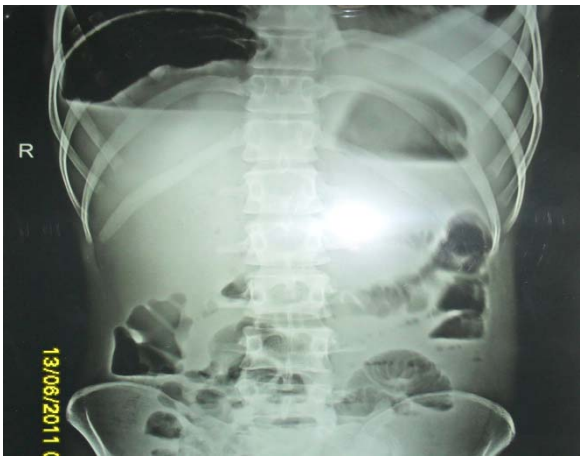
Chilaiditi syndrome is a rare condition when pain occurs due to transposition of a loop of large intestine (usually transverse colon) in between the diaphragm and the liver, visible on plain abdominal X-ray or chest X-ray. It is also known as certain other name like Interposition Hepatodiaphragmatica; Subphrenic Displacement of the Colon; Subphrenic Interposition Syndrome; Pseudopneumoperitoneum etc.

Clinical presentation of Chilaiditi syndrome may be Asymptomatic or with symptoms like abdominal pain, vomiting, anorexia, constipation, flatulence, air swallowing or feeling of pressure in upper abdomen when upright

In this paper we emphasis that each and every case of free gas in plain x-ray abdomen should be sought and thought clinically to avoid unnecessary negative laprotomy.

CASE REPORT

A 18 year old male patient presented to emergency surgical department of our hospital with chief complain of abdominal pain with fever for 15 days. Patient was conscious and oriented to complain of abdominal pain. Patient was hemodynamicaly stable with pulse rate of 80/min and blood pressure of 126/80 mmhg. His Glassgow coma scale was 15/15, respiratory rate 18/min and SPO_2 99% on air. Palpation of abdomen was soft with mild tenderness in right hypochonrium and rest abdominal palpation was normal. Bowel sounds were sluggish. One finger hepatomegaly was present.



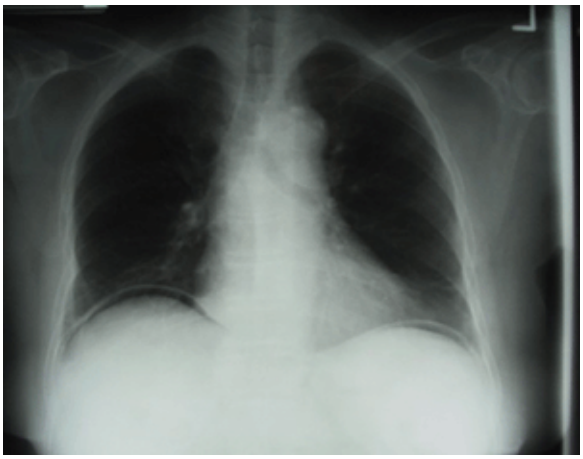


Figure 1 & 2: X-ray images of patient diagnosed as Chilaiditi syndrome

After initial resuscitation x-rays and ultra sonography was done. Chest x-ray PA view and abdomen standing reveal free gas under right dome of diaphragm. At serial interval x-rays were taken. All of them reveal free gas under right side of diaphragm only. There was no gas under left side of diaphragm except stomach shadow. There was mild pleural effusion on left side. Ultra sonography of abdomen suggested hepatomegaly and gall bladder wall thickening. There was moderate free fluid in peritoneal cavity with thick internal septations predominantly in pelvis.

DISCUSSION

On first impression it appeared bowel perforation but detailed clinical examination of patient was not suggesting any sign or symptoms of bowel perforation. Patient was vitally stable and abdomen was soft on palpation without any guarding or rigidity. There was also no any positive history that can favour diagnosis of perforation. So decision was taken to manage patient conservatively. At this point patient was suspected of having chilaiditi syndrome which was supposed to be proved later on.

Routine workup done and patient appeared Hepatitis E reactive. Blood parameters of this patient were as under as follows, Hemoglobin-14.2 gm per dl; WBC count - 27000 per cumm; Platelets -3,04000; PT test 20 sec, control 14 sec; INR 1.42; Blood sugar -52; S.urea-45, S. creatinine- 0.8; S. bilirubin total -11.4mg (direct-5.4, indirect-6.0); SGPT-399; SGOT- 316; ALP-592; Sodium-133; and Potassium-3.8.

TREATMENT

The First line of treatment given was Intravenous fluids and Intravenous antibiotics. Patient kept on nil by mouth. Simultaneously GI tract decompression was done by Ryle's tube insertion and active aspiration continuously.

Final Line of Management was decided after confirmation of diagnosis. This includes fat free diet; plenty of glucose powder orally; intravenous antibiotics for 5 days; intravenous pantoprazole; intravenous buscopan; injectable multivitamin; injectable dextrose 10% intravenously; Syrup lactulose 2 teaspoonfull three times a day; and lactulose enema as an when required.

Starting from third day patient passed stool daily and and improved significantly. Jaundice decreased gradually. Heaptitis markers came to baseline level in 10 days. However free gas under right dome of diaphragm was present persistently even after 10 days.

Digital x-ray plates of extramount quality taken and patient diagnosis confirmed of having the mysterious chilaiditi syndrome. Though it has incidence rate as low as 0.1% only, we were victim of patient of this rare syndrome - Chilaiditi Syndrome.

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