Recurrent evisceration from McBurney’s incision

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CASE REPORT

A 71-year-old, male presented to emergency room with 24 hr history of right lower quadrant (RLQ) pain, anorexia and low-grade fever. His past medical history included hypertension, asthma, COPD and cerebral palsy. Patient was disabled with severe flexion deformity at the hip joint. On physical examination he was tachycardic, hypotensive and had RLQ tenderness without peritonitis. Blood tests showed white cell count of 7.6x10^3 cells/mm^3 and hemoglobin of 10.4 g/dl. Computed tomography (CT) scan (Figure 1) showed dilated fluid filled appendix (1.1 cm), with fat stranding confirming acute appendicitis (Figure 1).

He was resuscitated, given antibiotics and an emergent open appendectomty performed. Post operatively patient was on the surgical floor but was transferred to the ICU for acute exacerbation of COPD and was started on short course steroids in addition to nebulizers. He recovered over the next few days and transferred to the surgical floor. While awaiting placement to a skilled nursing facility on post op day seven he eviscerated bowel through the McBurney’s incision while having a bowel movement (Figure 2). He was taken to the operating room emergently, bowel was reduced and incision primarily repaired with retention sutures. Patient remained in the hospital and he eviscerated again on the post op day eleven (Figure 3). This time after the bowel was reduced the defect was repaired with a biological mesh and wound approximated with closely placed retention sutures (Figure 4). The patient remained intubated for a week after which tracheostomy was performed due to inability to wean off ventilator. The patient was in the ICU for four days then transferred to a long-term acute care center where he improved over the next four weeks. On follow up his incision healed well.

DISCUSSION

Evisceration or Burst abdomen via laparotomy incisions is rare. [4] The incidence of evisceration after open appendectomy through a McBurney’s incision is not clearly known and the recurrence of such evisceration has never been documented in the recent literature. There are multiple layers of fascia and muscles with good blood supply which lead to good healing thus preventing evisceration. The major independent risk factors for evisceration through midline incision are old age, male gender, chronic pulmonary disease, ascites, jaundice, anemia,

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Figure 1: CT scan showing inflamed and dilated appendix.
mentioned were for eversion through a midline incision but they should hold good for the Mcburney’s incision as well. Other than the patient factors the surgeon can prevent or reduce incidence of eversion by following good surgical principles. Well-done, large, prospective studies with the best follow-up found that a Suture Length (SL)-to-Wound Length (WL) ratio of approximately 4:1 minimized the incidence of fascial dehiscence and incisional hernia formation [2]. The pathognomonic sign of eversion or burst abdomen is the discharge of serosanguinous (salmon colored) fluid from the wound [5]. The diagnosis of eversion is clinical with the identification of intra-abdominal contents through the incision. The preferred treatment of eversion is an emergent reclusion [5]. Our patient had an emergent repair with reduction of bowel and primary closure with retention sutures on the first re-operation. On second re-operation he underwent primary closure reinforced with biological mesh and closely placed retention sutures. The mortality and morbidity of eversion is high [5].

CONCLUSION

Eversion is occasionally seen in midline laparotomy incisions in high-risk patients but exceedingly rare in Mcburney’s incision.

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Guarantor
The corresponding author is the guarantor of Submission.

Conflict of Interest
The authors declare no conflict of interest.

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REFERENCES