

A Case Study

Vestige of Vitello Intestinal Duct

By Miss Leela Joseph*

A 13 year old boy was hospitalized on with the complaints of abdo-pain on and off since 4 weeks. He had also complained of frequency of micturation on and off since 3 years. There was no history of dysentery or haematuria.

On admission Temp. 98.8°F., Pulse 88/mt. Resp. 18/mt. General and local examination did not reveal any positive findings. Following were the investigations done :

Blood Hb. 12.5 gms%, Tc. 8000/cu mm. Dc. Poly 70%
Lymph 30%

Urine : Routine-negative, Microscopy, WBC 2-3/HPF. Epi. cells present. Plain X-ray abdomen N.A.D.

His symptoms seemingly disappeared with analgesics and anti-spasmodics and was discharged ten days after admission. He visited the O.P.D. again a week later with the complaint of pain around the umbilicus and was admitted for further treatment and investigation. At the time of admission Temp. was 98°F. Pulse 88/mt. Resp. 20/mt. He was put on Seclomycin $\frac{1}{2}$ gm. I M OD, Tab. Baralgan I BD, Mist. Carm. dram IV tid. His hygienic and comfort needs were taken care of. As the patient complained of persistent abdo-pain the Surgeon in-charge decided to perform Laparotomy on him.

Consent was taken, and mental and physical preparations were done including the routine preparations for Laparotomy.

He was operated upon under General Anaesthesia. As the peritoneum was opened a big congenital band (Vestige of vitello intestinal duct) was visible extending from the umbilicus to the inferior mesentery. The band was seen to compress the urinary bladder too. The structure was excised after ligating both ends. Abdomen was closed in layers as usual.

Before proceeding to the post op-care let me add a few lines on Vitello intestinal duct.

At an early developmental stage the midgut communicates with the yolk Sac. This communication is

the Vitello intestinal duct also called the omphalomesenteric duct. Normally it entirely disappears. Vestiges of it may persist. In some cases a fibrous band remains which represents the vessels of the duct (Vitelline) and passes from the umbilicus to some part of the mesentery or small gut.

Its importance lies in the fact that.—

(a) It may act as a band under which a loop of gut may be compressed so causing obstruction. It may compress other abdominal organs also

(b) It may be attached to some part of the mesenteric artery. If it be pulled on in abdominal operations it may tear the blood vessel to which it is attached and cause fatal haemorrhage. (Meckel's diverticulum, enterotomate etc are other vestiges of vitello intestinal duct.)

He returned to post op-bed, when his BP was 110/80mm of Hg. pulse 100/mt., BP & Pulse Chart was maintained $\frac{1}{2}$ hourly till they were steady. Glucose 5% was infused. He was given a shot of pethedine 50 mg in the morning. There was no oozing from the wound. Pressure points were cared for. Position was changed many-times and he was kept comfortable. Sips of coffee were given from evening. He voided, and had a good sleep with pnenobarb gr. I at H.S. He indeed had an uneventful post op-period.

On the first post op-day he was out of bed for sometime. His hygienic and other heeds were met daily, and was getting Vit.C. 100 mg. TID, Novalgin I TID, Mist Carm. IV TID. Till the 3rd day he was given soft diet, followed by regular diet. Condition of the wound was good. Stitches were out on the 8th day and union was good. He was cheerful and co-operative. He did not complain anymore of abdo-pain or frequency of micturation. Health instruction were given during the course of his stay. He was discharged in a good condition with advice for check up.

Midwifery—(Contd. from page 45)

care of the baby is of great benefit to the mothers. The use of Entonox, a mixture of 50% N₂O and 50% O₂, gives the patient much relief in the first and second stages of labour. We all had an opportunity of taking part in the group exercises in the clinics and in teaching the mothers. The patients learned in the clinic about the use of Entonox and how to obtain the maximum benefit from the use of the gas.

During the first week of the course all of us were much concentrated in trying to witness deliveries and deliver a patient on our own again. After that we felt more free to go in and out amongst the patients, to ask questions, and practice any technique new to us. Amongst those was incubation of the new born baby which we practised on the doll. We also observed the use of the monitor. This is an instrument which electronically records the baby's heartbeat in utero, and shows the length and strength of the uterine contractions.

It is customary now-a-days to evaluate at the time of delivery the baby's condition according to a method known as the APGAR score, named after the lady doctor who brought this type of evaluation into use. The score is given from one to ten, ten being the score for a baby who breathes and cries at birth, whose muscle tone is good, who has normal reflexes, and whose condition is in every way satisfactory. The score is taken at one and then at five minutes. Any baby with an UPGAR score of from five to seven needs to be watched, while a baby whose score is below five will need constant care and attention. The scores are recorded. Low scoring is an indication for including the baby's name on the "at risk" register of the Local authority, and is useful for assessment of the child in later life.

Another useful part of our course was learn about new drugs used in midwifery today and get to know what publications are available and the various firms providing equipment for use in midwifery. By the end of our two weeks we gained new knowledge and became anxious for a chance to put it into practice. □

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Reference—Alec Mc Gregor, A synopsis of surgical Anatomy (9th ed.).