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A Retrospective Analysis of Valentino's Syndrome a Diagnostic Dilemma

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Conflicts of Interest: Nil

Abstract

Background: Valentino's syndrome is acute pain in right lower quadrant of abdomen following perforation of peptic ulcer. As it is acute condition of right lower abdominal pain it is mimicking as acute appendicitis. It is named as Rudolph Valentino, was an Italian-born American actor suffered from right lower quadrant abdominal pain which turned out to be perforated peptic ulcer. He was finally died from an infection resulting from surgery attempting to repair the perforation. After perforation of peptic ulcers fluid and content trickle down toward right paracolic gutter finally causes pain right lower quadrant pain by irritating the peritoneum. Symptoms, signs and blood picture of the disease are same as presenting acute appendicitis. Hence it is a big challenging deal to surgeons.

Methods: we discuss an analysis of 34 cases of valentino's syndrome with emphasis on presentation, diagnosis, management of the disease.

Results: In our study mean age of presentation is 47 years, most commonly affected are male. Most common presenting symptom is pain lower abdomen especially lower abdomen 34(100%). Contrast enhanced computer tomography correctly detected 32 cases (94.11. %) sensitivity is 94.44%. Most common site is Duodenum in 29(85.29%) cases. About post-operative complications most common is pneumonia 10 cases (29.41%). Mortality within 72 hours was 3 cases (8.82%).

Conclusion: Perforated peptic ulcers can present as a right lower abdominal pain and is likely to be misdiagnosed as an acute appendicitis. So we should always keep in mind a rare but potentially life threatening disease Valentino's syndrome.

Keywords: Valentio's syndrome, acute appendicitis, Peptic perforation, Grahm's operation, Right iliac fossa.

Introduction

The peptic ulcer defined as defects in the gastrointestinal mucosa that extend through the muscularis mucosae. It is a multifactorial disease [1]. Dietary habits, smoking, Nonsteroidal anti-inflammatory drugs, *Helicobecter Pylori* infection are the etiological factors [2]. Though its incidence, prevalence and complications are decreasing in developing countries in India especially southern india are still increasing [3, 4].Gastric perforation is 10-15% in contrast to duodenal ulcer is 85-90% [5]. Peptic perforation is associated with peptic ulcer disease is 2-14% [6]. Perforation may be the first symptomatic presentation of peptic ulcer disease [7]. It is a rare but life threatening condition mortality is 10% to 40% [8]. Perforation of peptic ulcer usually presented with pain abdomen, nausea, vomiting, altered mental status, fever, hypotension, dehydration, tachycardia with a history suggestive of peptic ulcer disease, X- ray shows gas under diaphragm, leucocytosis with neutrophilia [1, 8, 9]. Content leaked from the perforated peptic ulcer may trickled down to the right paracolic gutter finally causing

local peritonitis of right lower quadrant mimicking as an acute condition and may be misdiagnosed [10, 11,12]. Here we have discussed about rare atypical presentation of perforated peptic ulcer valentine's syndrome, diagnosis, and management.

Materials and Methods

It's a retrospective study over a period of 3 years 6 months from January 2014- June 2017 including follow up. We have collected data of previous 3 years 6 months total 34 cases diagnosed as a Valentino's syndrome were treated in the department of General surgery at M.K.C.G Medical College. Inclusion criteria were Perforated peptic ulcer presenting as a right lower abdominal pain mimicking an acute Appendicitis, Age groups >15 years <75 years. Exclusion criteria were perforation due to any trauma, age <15, >75 years, any history of previous peptic ulcer disease, others associated bleeding ulcers. We took careful history, clinical examinations, blood investigations, X- Ray chest and abdomen in erect posture, Ultrasounds of abdomen and Contrast enhanced Computer tomography scan of abdomen pelvis, blood investigations. Correction of dehydration with wide bore intravenous cannula, Ryle's tube aspiration and broad spectrum antibiotics, then all 34 cases with exploratory laparotomy and peritoneal lavage with or without omental patch. For post-operative managements nothing per orally, ryles tube aspiration, intra venous broad spectrum antibiotics coverage, intravenous fluids and pantoprazole. Discharge the patients with a protection with H. Pylori kit for eradication and prevention of further complication. Follow up with upper gastrointestinal endoscopy after 6 weeks.

Results

In our study mean age of presentation is 47 years. Most of age groups 45-60 years 16 out of 34 (47.05%) least in 15-30 years only 3 (8.82%) chart1. Male and female ratio is 2:1 (Chart 2). Most common presenting symptom is pain lower abdomen especially lower abdomen 34(100%), least common is altered sensorium 1 (2.94%), Common sign is tenderness over right iliac fossa 29 (85%), in contrast rebound tenderness and hypotension is only 3 (8.82%) Table 1. Investigation of the disease by routine blood investigation showed leucocytosis that is >11000 cells/ mm^3 in 28 (82.35%). X-Ray chest reveals gas under the diaphragm is only 14 (41.17%), multiple air fluid level suggestive of sub-acute intestinal obstruction 7(20.5%) sensitivity of X- Ray in the diagnosis is 62.96%, peritoneal collection around the appendix and appendix not visualised in ultra sound of abdomen is 23 (67.64%) sensitivity of this test is 75.56%, Contrast enhanced computer tomography shows pneumoperitoneum, peritoneal collection in 32 cases (94.11. %) sensitivity is 94.44% (chart3). All cases were operated with midline incision in 20 (58.8%), right Para median in 10 cases (29.41%), Mc Burney's grid iron incision in 4 cases (11.76%). Perforation sites are in Stomach 5 (14.70%) 3 was benign and 2 cases are malignant gastric ulcer confirmed by biopsy, Duodenum in 29(85.29%) cases among 29 cases 25 was frank perforation and 4 was sealed duodenal perforation. Operation performed only peritoneal lavage with sterile saline and abdominal drains in 4 patients (11.76%), modified Grahm's operation (closure of perforation with suturing and free omental patch) in 30 cases (88.23%). About post-operative complications most common is pneumonia 10 cases (29.41%), followed by wound infection in 7 cases (20.58%), least common is leakage from repair only 1 cases (2.94%). Long standing complication incisional hernia in 2 cases (5.88%). Mortality within 72 hours was 3 cases (8.82%) Chart 4. Post-operatively all 28 cases except 3 who were malignant gastric carcinoma received treatment with H. Pylori kit and reviewed after 6 weeks

with upper gastrointestinal endoscopy revealed healed ulcer in 23 cases (82.14%).

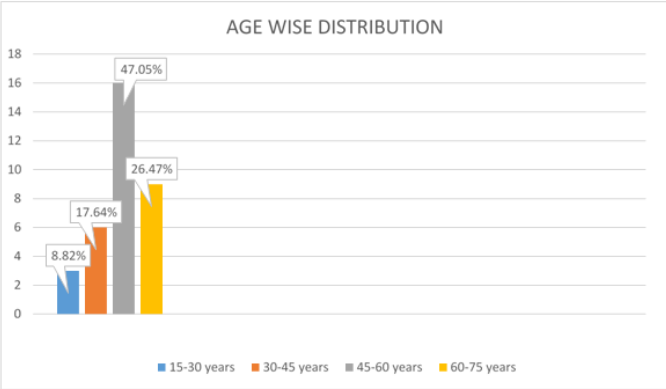

Chart 1. Bar diagram showing age wise distribution.

Chart 2.bar diagram showing sex wise distribution

Symptoms and Signs	No of patients	Percentage
Pain right lower abdomen	34	100%
Obstipation	18	52.94%
vomiting	12	35.29%
Fever	9	26.47%
Altered sensorium	1	2.9%
Right iliac fossa tenderness and rigidity	29	85.29%
Tachycardia	23	67.64%
Absent of bowel sound	17	50%
Raised surface temperature	16	47.05%
Obliteration of liver dullness	12	35.29%
Tachypnoea	8	23.52%

Table 1. Symptoms and signs of Valentino's syndrome

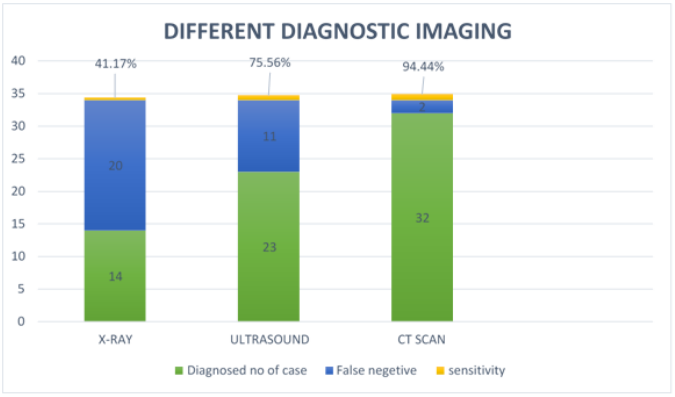

Chart 3 Different diagnostic imaging and its sensitivity

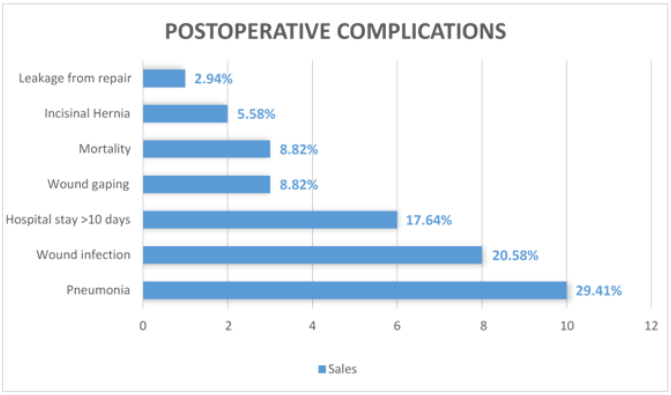

Chart 4 bar diagram showing post-operative complications

Discussion

Every year peptic ulcer disease affects 4 million people around the world [1]. Main causative factors of peptic perforation is Nonsteroidal inflammatory drugs, H. Pylori infection, spicy diet it mostly affect in male and mean age of presentation is 48 years [13]. In our study also showed male predominance and mean age is 47 years in a 45-60 age groups. Mainly presenting symptom in valentino's syndrome is right iliac fossa pain and tenderness on palpation. It is supported by Yu J, F ulcher AS, Turner MA, e t al showed perforated peptic ulcer can present as an acute pain in right lower abdomen [10]. Perforated peptic ulcer in 5- 10% cases may present with hypotension [14]. In our case it is 8.82% and supporting the fact. In our study liver dullness is obliterated in 35.29% another study showed it was 37% [15]. In our study it is clearly showed that only X-Ray will not be so helpful, Ultrasound picture may be like acute appendicitis

but computer tomographic scan may detect perforated peptic ulcer more accurately [10- 12]. With current radiological techniques, 80–90% of cases are correctly diagnosed [14]. Perforated peptic ulcer mostly duodenal and less are gastric ulcer and it can be carcinoma in gastric perforation [15, 17]. The peptic perforation is an essentially emergency condition, in case of duodenal perforation a duodenal ulcer closure with an omental patch is well-established as the optimal procedure [16, 18]. But in gastric perforation always biopsy should be taken [17, 19]. Regarding post-operative management ryles tube aspiration and early oral feeding is still controversial [20, 21]. Some study support ryle's tube aspiration and delayed oral feeding, some showed no change of outcome by doing this. In our study most common postoperative complication is wound infection, followed by chest complication [22, 23]. To avoid wound infection we should use broad spectrum antibiotics [24]. Post operatively Clarithromycin, amoxycillin, proton pump inhibitor should be given [25]. Patient should be follow up every 6 weeks by endoscopy.

Conclusion

Perforated peptic ulcers can present as a right lower abdominal pain and is likely to be misdiagnosed as an acute appendicitis. So we should always keep in mind a rare but potentially life threatening disease Valentino's syndrome. To diagnose the disease CT scan of abdomen is very helpful. Exploratory laparotomy may be needed in some cases. Closure of perforation and omental patch is an optimal procedure for management. Early diagnosis and management of the disease with resuscitation is the key of success.

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