

Ectopic testicular tissue, vas deferens and epididymis with ileo-jejunal atresia – a rare case report

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Abstract

Introduction: Intestinal atresia can involve any portion of the small bowel. It is characterised by an obliteration of the bowel lumen and its replacement by a fibrous cord that connects proximal and distal segments. Its incidence is 1:2500/5000 live births and the most common locations are distal ileum (36%) and proximal jejunum (31%). However, chromosomal abnormalities are not associated with the jejunum or ileal atresia/stenosis. Risk of intestinal atresia/stenosis increases with lower birth weight and lower gestational age. **Objectives:** To make aware that Ileo-jejunal atresia can occur with ectopic testicular tissue, vas deferens and Epididymis. **Case History:** Biopsy from a preterm low birth weight baby born at 32-34 weeks gestation with the complaints of not passing stool since 8-10 days was received. Gross - two small segments 1. Atretic fibrous cord like segment of ileum measuring 2cm in length; lumen obliterated. 2. Jejunum of length 3cm with one end blind and other showed a patent lumen; serosal and mucosal congestion seen. Sections stained with haematoxylin and eosin. **Results:** Severe submucosal congestion and myohypertrophy of the muscular layer of jejunum with atretic fibrous cord like ileum with ectopic testicular tissue, epididymis and vas deferens tissue; consistent with ileal atresia. **Conclusion:** Incidental finding of ectopic tissue is common in atretic segment while examining the atretic segment of small intestine we should be aware of ectopic tissues which can be seen and there is no literature at present on the above topic.

Keywords: Ileo-jejunal atresia, Ectopic testis, Vas deferens, Epididymis.

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INTRODUCTION

Intestinal Atresia can involve any portion of the small bowel. It is characterised by an obliteration of the bowel lumen and its replacement by a fibrous cord that connects proximal and distal segments.¹ Duodenal atresia is associated with a higher incidence of congenital malformation than jejunoileal atresia. Atresia of jejunum and ileum are common causes of bowel obstruction in the neonate. Jejunoileal Atresia is a condition acquired during foetal development due to disruption of mesenteric blood

supply.² Its incidence is 1:2500/5000 live births and the most common locations are distal ileum (36%) and proximal jejunum (31%). Risk for intestinal Atresia/stenosis increases with lower birth weight and lower gestational age.³

CASE REPORT

A G2P2L2 mother delivered a low birth weight male child at 32-34 weeks gestation, with birth asphyxia and hyperbilirubinemia with the complaints of not passing stool since 8-10 days. General examination – Febrile, HR- 190/m, RR- 36/m, pallor++, icterus++. Systemic examination – Mild abdominal distension. X ray – multiple air fluid levels seen. Serum bilirubin : Total-10.45mg%, Direct – 2.71mg%, Indirect – 7.74mg%. Gross examination: Two small segments

1. Atretic fibrous cord like segment of ileum measuring 2cm in length; lumen obliterated.
2. Jejunum of length 3cm with one end blind and other showed a patent lumen; serosal and mucosal congestion seen.

Microscopic Examination

- Multiple sections through jejunum shows severe submucosal congestion and myohypertrophy of the muscle layer.



Figure 1: shows multiple air fluid levels



Figure 2: Invertogram rules out perforated anus

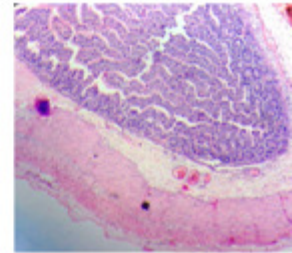


Figure 3: shows severe submucosal congestion and myohypertrophy of the muscle layer

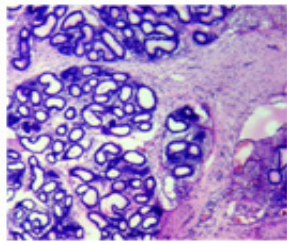


Figure 4: Shows immature seminiferous tubules separated by fibrous stroma

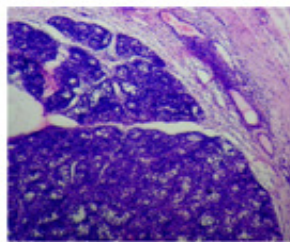


Figure 5: Shows histology epididymis

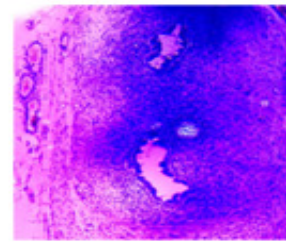


Figure 6: Shows vas deferens

- Multiple sections through ileum shows atretic fibrous cord like ileum with ectopic testicular, epididymis and vas deferens

DISCUSSION

More than one third of congenital bowel obstruction results from intestinal atresia. Although duodenum is the most common site, the jejunum and ileum account for 39% of intestinal atresias.⁴ In Jejunoileal atresia, the location of the defect is at proximal jejunum in 31% of the cases, distal jejunum in 20%, proximal ileum in 13 % cases and distal ileum in 36%.⁵ Successful management depends on timely diagnosis and referral for therapy. The diagnosis is based on history (Symptoms), physical examination (signs) confirmed by some investigations such as radiographic and histopathological studies.⁵ There is higher incidence of associated major congenital extra intestinal malformation in JA compared with IA.⁴ Small intestinal atresia has been reported to run in families.⁶ Prenatal sonographic findings and time of diagnosis did not affect neonatal outcome in case of congenital jejunal and ileal atresia.⁷

CONCLUSION

In our case Jejunoileal atresia is of type II. Associated congenital anomalies includes omphalocele, cardiac, skeletal, renal, concurrent duodenal atresia, associated colonic atresia and central nervous system malformations.

However, incidental finding of ectopic tissue in the atretic segment of small intestine should be kept in our mind which can be seen as in our case.

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