Case report
https://doi.org/10.23934/2223-9022-2021-10-1-187-195

Atypical Manifestation of Crohn's Disease in a Teenage Girl

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ABSTRACT Crohn's disease (CD) is nonspecific granulomatous inflammatory disease of all layers of the intestinal wall, characterized by a variety of clinical forms, heterogeneity of age groups of children and extraintestinal manifestations. The diagnosis of the disease is difficult due to the presence of many symptoms specific to a number of other surgical diseases of the abdominal cavity organs. This diagnosis is often made intraoperatively. In this study we report a case of treatment of a teenage girl who was admitted with complaints of a mass in the right iliac region extruding above the skin surface, instability of body weight, an increase in body temperature to 37.2° C for one month. As a result of laboratory and instrumental examination, the etiology was not established. Laparoscopy revealed abdominal infiltrate, consisting of the cecum, the distal ileum and a part of the greater omentum, tightly fixed to the anterior abdominal wall, which led to the destruction of the peritoneum, muscle tissue and aponeurosis with further infiltration into the sub-cutaneous fat. Appendectomy and separation of the infiltrate were performed. After that, the girl was discharged due to the categorical refusal of the parents of the further treatment.

Twelve days later the patient had abdominal pain again, the dynamics of the pain syndrome intensified, the body temperature was febrile. After examination and detection of signs of peritonitis, emergency laparotomy, subtotal resection of the greater omentum, separation of the abdominal infiltrate (repeated), sanitation and drainage of the abdominal cavity were performed. During the surgery, the access to the abdominal cavity was performed with technical difficulties due to the fact that a conglomerate of intestinal loops and omentum was fixed to the anterior abdominal wall from the interior. The conglomerate was separated from the anterior abdominal wall by blunt dissection. The size of the conglomerate was up to 12–15 cm, formed by the transverse colon, the ileum and the greater omentum. The walls of the transverse colon and ileum in the area of the conglomerate had the cartilaginous density. For the purpose of further examination and determination of tactics for further treatment, the child was transferred to the Gastroenterology Department with a diagnosis of "Terminal ileitis. Purulent omentitis. Serous peritonitis. Mild normochromic anemia of mixed origin. Crohn's disease?" After the additional examination in a specialized hospital, the diagnosis of CD was confirmed.

Keywords: Crohn's disease, terminal ileitis, diagnosis, children, surgical treatment, resection, intestinal diseases

For citation Gavrilyuk VP, Donskaya EV, Kostin SV, Severinov VP, Zakutayeva LY. Atypical Manifestation of Crohn's Disease in a Teenage Girl. *Russian Sklifosovsky Journal of Emergency Medical Care*. 2021;10(1):187–195. https://doi.org/10.23934/2223-9022-2021-10-1-187-195 (in Russ.)

Conflict of interest Authors declare lack of the conflicts of interests

Acknowledgments, sponsorship The study was performed in accordance with the research plan of the Kursk State Medical University of the Ministry of Health of Russian Federation. The authors did not receive financial support from the manufacturers of pharmaceuticals and medical devices

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CD – Crohn's disease
GIT – gastrointestinal tract
KRCH № 2 – Kursk Regional Children's Hospital № 2
CT – computed tomography
MRI – Magnetic Resonance Imaging
b.m. – body mass
DAR – Department of Anesthesiology and Reanimation
AO – abdominal organs
OCh – organs of the chest
RCCH – Regional Children's Clinical Hospital
SHOL – symptom of a hollow organ lesion
USE – ultrasound examination
CDM – color Doppler mapping

INTRODUCTION

Crohn's disease (CD) is a nonspecific primary chronic, granulomatous inflammatory disease involving all layers of the intestinal, less often gastric wall, characterized by intermittent (segmental) damage to various parts of the gastrointestinal tract (GIT) [1, 2]. The question of the etiology of this pathological condition remains open; it has now been proven that the development of CD is the result of the interaction of genetic and external factors. [3, 4].

The incidence of CD is about 0.1% [5]. The peak incidence occurs in most cases during adolescence. In 50% of cases, there is a lesion of the terminal ileum and ileocolitis (according to the Montreal classification) [6, 7]. The variety of clinical forms of the disease is associated with the involvement of various parts of the gastrointestinal tract in the inflammatory process, the heterogeneity of the age groups of sick children (from infancy to older adolescents) and extraintestinal manifestations of the disease [8, 9]. A common form of CD is acute terminal ileitis, which is usually disguised as a clinical picture of acute appendicitis (diarrhea, nausea, vomiting, fever up to 38–39° C*, pain in the projection of the right iliac fossa) [10]. As a rule, most of the described observations highlight precisely the emergency cases of appealing to a pediatric surgeon for abdominal pain, which either arose acutely or became unbearable. [11]. And this, in turn, may indicate the neglect of the process and often about the need to perform emergency surgical intervention [12].

Both in domestic and foreign literature, there is a large number of works devoted to the analysis of cases of unusual manifestation of CD. However, they are all private in nature - colleagues share their experience regarding the tactics of treatment and diagnosis of such an exotic disease [13]. Despite the fame of the pathology due to its formidable surgical complications (as a rule, the development of intestinal obstruction, bowel perforation, etc.), there are a number of unresolved questions regarding intraoperative tactics, the volume of urgent examination when the child first seeks medical help.

Purpose of the work — by demonstrating a clinical case of atypical manifestation of CD (volumetric formation in the projection of the right iliac fossa) to actualize the issue of the complexity of diagnosis and management of patients with this pathology, along with emergency appendicitis-like conditions.

Clinical case

I hospitalization (suspected abdominal formation)

In the evening, at the admission department of the Kursk Regional Children's Hospital

No. 2 "(KRCH No. 2), a 14-year-old female patient S. came to complain of pain, the presence of a formation in the projection of the right iliac fossa, instability of body weight (bw), an increase in body temperature up to 37.2 ° C during the last month. Upon detailed questioning, it was found that the patient was ill for about a month and a half, when for the first time, against the background of complete well-being, Quincke's edema appeared, with an increase in body temperature to 37.2°C. There was a positive trend against the background of the introduction of dexamethasone. Three similar episodes were noticed within 2 weeks. It is also known from the anamnesis that the girl is observed by a gastroenterologist on an outpatient basis for chronic gastroduodenitis. During this period of time and to the present time, recurrent abdominal pains without clear localization, instability of the MT, tendency to lose weight, preservation of subfebrile condition are disturbed. Three days before treatment the patient notes an increase in abdominal pain localized in the right iliac region, the presence of an education in this area, an increase in body temperature to 38,7°C. Parents independently applied to KODB No. 2, where the girl was hospitalized on an emergency basis.

On examination - the belly of the correct shape and size. On palpation, painful in the right lateral region, where local muscle tension is determined, as well as a volumetric formation of dense consistency, inactive, painful, measuring 5.0x6.0 cm, rising above the skin surface by 0.5 cm. Appendicular symptoms (Rovzing, Sitkovsky, Obraztsov), symptoms of peritoneal irritation (Shchetkin-Blumberg, Voskresensky) are negative.

Due to the unclear genesis of education, the child was examined urgently. According to the ultrasound of the abdominal cavity organs (ACO) in the projection of the right iliac fossa, a hypoechoic heterogeneous formation with hyperechoic inclusions measuring 30x25x26 mm is determined, the contours are quite clear, uneven (bumpy). With color Doppler mapping (CDM) - there is blood flow in the formation. Adjacent to this formation is an intestinal loop with walls thickened up to 5-6 mm and sluggish peristalsis, blood flow in the intestinal wall is enriched. Around this the echogenic background is presented. Small pelvis contains a small amount of free liquid up to 15 mm high. To the left of the bladder, a structure similar to an ovary with follicles is located, to which a thin-walled, anechoic formation with dimensions 58x74x65 mm is located, with CDC without blood flow, blood flow in the ovary is determined. The bladder is slightly displaced to the left. The parenchymal organs are not changed. Conclusion: volumetric formation of the abdominal cavity. Left ovarian cyst?

A series of radiographs was performed:

— plain chest x-ray: no focal and infiltrative shadows were found. The pulmonary pattern in the basal regions and lower medial regions is enriched due to interstitial changes, thickened. The sinuses are free, the contours of the diaphragm are clear. The shadow of the mediastinum is displaced to the left due to laying of the patient, its boundaries are clear;

— plain radiography of AO — free gas, liquid levels are not detected. The gas bubble of the stomach is not pronounced. Intestinal pneumatization is moderately increased in the middle floor of the abdominal cavity;

— X-ray of the pelvic bones in direct projection: visible and destructive changes in the pelvic bones are not determined.

Considering the results obtained, as well as the positive dynamics: a decrease in body temperature and a decrease in the intensity of abdominal pain syndrome against the background of infusion therapy with isotonic solutions, we decided to refrain from active surgical tactics and continue monitoring the child for further in-depth and comprehensive examination.

In the morning, the patient was collectively examined by doctors - pediatric surgeons, the head of the department, employees of the Department of Pediatric Surgery and Pediatrics of the FPO FSBEI KSMU of the Ministry of Health of Russia, based on the results of the consultation, a plan for laboratory and instrumental examination of the child was formed, the results of which are presented below.

Ultrasound of the AO and small pelvis on the 2nd day after hospitalization (on the basis of a gynecological hospital): functional cyst of the left ovary (paraovarian cyst?). Forming of the right iliac fossa.

Computed tomography (CT) of the CO, AO, retroperitoneal space and the pelvic area with intravenous contrast (Yogeksol 40.0 ml): the data obtained may correspond to the volumetric formation of the Douglas space (more data for a large left ovarian cyst); ascites; severe right-sided scoliosis (Fig. 1).

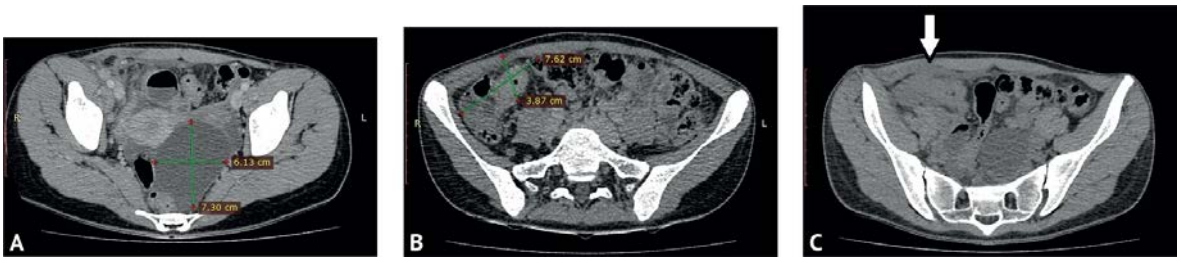

Fig. 1. CT scans of the patient's small pelvis at different levels: A — the size of the paraovarian cyst on the left is indicated; B — the size of the infiltrate of the right iliac fossa; C — the white arrow indicates the place of deformation (destruction) of the tissues of the anterior abdominal wall in the area of contact with the infiltrate

Consultation of gynecologists (again) on the 5th day after hospitalization (on the basis of a gynecological hospital): Appendicular infiltration? Infiltration of the right iliac fossa? Left ovarian cyst (functional).

Magnetic resonance imaging (MRI) of the small pelvis on the 7th day after hospitalization: MR-picture of the cystic formation of the left ovary (to differentiate the follicular cyst and serous cystadenoma).

Ultrasound of the OBP on the 7th day after hospitalization (on the basis of an oncological dispensary): a symptom of a hollow organ lesion in the projection of the blind and ascending colon (Susp. CD, Susp. Lymphoma, Susp. Appendicular infiltrate). Mesenteric lymphadenopathy. Cystic formation of the left ovary. Hydropelvix.

Based on the data obtained, it was impossible to establish the etiology of the formation, a preliminary diagnosis was made: Volumetric formation of the abdominal cavity. Appendicular infiltration? Large left ovarian cyst.

Collectively, a decision was made to perform surgical intervention in the amount of video laparoscopic revision of the AO with further determination of the tactics and scope of the intervention intraoperatively.

Under endotracheal anesthesia, after processing the operating field in the standard way through the lower umbilical point using a Verisch needle, a carboxyperitoneum was imposed, a trocar with a diameter of 5 mm for a laparoscope was installed. A laparoscope with a diameter of 5 mm was introduced. Working trocars were installed: in the left mesogastrium - 5 mm, in the left lateral region - 10 mm (with an adapter 5 mm), instruments were inserted. A revision of the abdominal cavity and small pelvis was performed.

During revision in the pelvic area - on the left: the ovary is located correctly, dimensions 8x8x9 cm, contains a single-chamber formation of a rounded shape 7x6 cm, the contents are "serous", with growth retroperitoneally in the area of the left mesosalpinx; The fallopian tube is visible throughout, 11 cm long, of the usual shape and size, the fimbriae are expressed. On the right are appendages without features. A surgeon-gynecologist, professor of the Department of Obstetrics and Gynecology, was invited to the operating room, who performed enucleation of the left ovarian cyst, the bed of the latter was coagulated with a bipolar electrocoagulator.

With further revision of the abdominal cavity: there is no effusion, the parietal and visceral peritoneum is smooth, shiny, in the upper and middle floors loops of the large and small intestine without pathological overlays. In the right iliac fossa, 4–5 cm above the uterine appendages, a dense immobile aperistaltic conglomerate measuring 10x15x5 cm (by the type of periappendicular infiltrate) is determined, consisting of welded loops of the thin and thick sections of the intestine, the greater omentum, fixed to the anterior abdominal wall. The right round ligament of the uterus is adjacent to its wall. The right appendages are intact. The walls of this formation of cartilaginous density. With significant technical difficulties, using an endodissector and a bipolar coagulator, the division of the anterior wall of the infiltrate (omentum strand and intestinal loop) was performed. Fragments of the greater omentum strand were taken for histological examination. After the separation of the anterior wall of the infiltrate, up to 2 ml of thick, creamy, old yellow pus was released - taken for flora, antibiotic sensitivity and Gram stain. The resulting cavity was washed with an aqueous solution of furacilin and was sanitized. The walls of the cavity are formed from above - by a strand of the greater omentum, on the right side and below - by intestinal loops. In this cavity, a vermiform process up to 5 cm long is determined, mobile, secondarily changed, injected with vessels, curved, located medially and down to the small pelvis. A decision was made to perform an appendectomy. Ligature appendectomy was performed with ligation proximally three times and once distal to 1.0 cm from the underlying ligature. The appendix was cut off with a bipolar electrocoagulator, removed through a 10 mm trocar and sent for histological examination.

When dividing the posterior wall of the conglomerate, attention was drawn to the rigid fixation of the omentum strand to the parietal peritoneum of the anterior abdominal wall. With partial separation of the fixed strand of the greater omentum, 3 ml of thick purulent content of yellow-white color with a large amount of detritus (soft tissues of the anterior abdominal wall) discharged. A cavity is determined in the thickness of the anterior abdominal wall 2x2x1 cm. The resulting cavity was washed with an aqueous solution of furacilin, sanitized.

The instrument inserted into the cavity was palpable under the skin. In the projection of the endoscopic instrument, a skin incision was made up to 1 cm long, a rubber drain was introduced to the infiltrate wall through the thickness of the soft tissues of the anterior abdominal wall destroyed by the purulent process. A tubular drain was inserted into the left iliac fossa through the trocar opening (port 10 mm) and installed into the pelvic cavity.

Considering the intraoperative data and the severity of the surgery, the child was transferred to the Department of Anesthesiology and Intensive Care (ORIT).

After the operation the following clinical diagnosis was made: the main one - "Torsion, necrosis of the greater omentum strand"; complication of the main diagnosis: “Purulent omentitis. Inflammatory infiltration of the abdominal cavity and right iliac fossa with destruction of soft tissues. Secondary appendicitis". Accompanying: "Cystoma of the left ovary".

The postoperative period was uneventful, on the 4th postoperative day the child was transferred to the surgical department. On the 9th postoperative day, the patient was discharged from the hospital.

II hospitalization (peritonitis)

Twelve days after discharge from the surgical department of KDB No. 2, the patient again had abdominal pain, in dynamics the pain syndrome intensified, the body temperature rose to febrile numbers. The next day after the onset of the above symptoms, the patient turned to KDB No. 2. Objectively - the abdomen was of the correct shape, size, on palpation, painful in the lower sections, peritoneal symptoms were determined, muscular defense was expressed.

Results of laboratory and instrumental examination upon admission:

Ultrasound of internal organs: in the right iliac fossa, a bowel loop with a pronounced thickened wall was determined, peristalsis is very sluggish. Below the navel, on an echogenic background, hypoechoic inclusions of 23x11 mm were determined, with fluid layers along the periphery.

Radiography of the chest and the abdomen: no focal shadows were detected, there was an enrichment of the pulmonary pattern, free gas and levels of fluid in the abdominal cavity were not detected.

Given the severity of the condition caused by the clinical manifestations of peritonitis, the child was hospitalized in the ORIT for preoperative preparation, after which a surgical intervention was performed in volume - laparotomy, subtotal resection of the greater omentum, separation of the abdominal infiltrate, sanitation and drainage of the abdominal cavity. During the operation, the entrance to the abdominal cavity was made with technical difficulties due to the fact that a conglomerate of intestinal loops and an omentum was soldered from the inside to the anterior abdominal wall. The conglomerate was separated bluntly from the anterior abdominal wall. The size of the conglomerate was up to 12-15 cm, it was formed by the transverse colon, ileum and greater omentum. The walls of the transverse colon and ileum in the area of the conglomerate of cartilaginous density, the separation of the infiltrate was very difficult due to the threat of ileal perforation. The area of the omentum, soldered to the ileum and transverse colon, was of a dirty gray color, sharply infiltrated; when it was separated, up to several milliliters of a turbid liquid were released. On the clamps and using electrocoagulation, a subtotal resection of the greater omentum was performed with stitching and ligation with lavsan. After the division of the conglomerate, the ileum was revised: the changed area of cartilaginous density was 10 cm long, its lumen was significantly narrowed, this area was located at a distance of about 8 cm from the ileocecal angle. The given section of the intestine was checked for tightness - the contents of the intestine and gas bubbles were not obtained. The transverse colon was changed in the central sections for about 10 cm along the antimesenteric edge, a check was made for tightness, the contents of the intestine and gas bubbles were also not obtained. With further revision of the abdominal cavity, no other pathology was found. Given the close location of the altered section of the ileum to the ileocecal angle, the absence of perforated holes, it was decided to refrain from performing resection of this section of the intestine. The abdominal cavity was sanitized with an aqueous solution of furacilin, and a tubular drain was installed to the altered part of the ileum. The abdominal cavity was sutured tightly.

After the surgery, the following clinical diagnosis was made: “Terminal ileitis. Purulent omentitis. Serous peritonitis. Normochromic anemia of mixed origin, mild. CD?».

On the 8th day after hospitalization, a control ultrasound of the internal organs was performed: the ileum remains with thickened walls up to 9–10 mm. The lumen is up to 6-7 mm (spasm). Air bubbles along the lumen. The blood flow is enriched. The surrounding background and loops of the small intestine are infiltrated. The ileal wall is hypoechoic. In the area of the postoperative wound without features. There is no effusion in the abdominal cavity. Conclusion: « Condition after surgery. Severe infiltrative changes in the ileum are a symptom of the affected hollow organ. CD?».

On the 10th day after the operation, the child's condition was stable. No complaints. The appetite was saved. Stool daily, decorated, without pathological impurities. There was no nausea or vomiting. The skin was clean. Respiration and hemodynamics were stable. The abdomen was not swollen, soft on palpation, palpable in all parts, painless. The postoperative wound healed by primary intention. The stitches were removed completely. For the purpose of further examination and determination of tactics for further treatment, the child was transferred to the gastroenterology department of the Regional Children's Clinical Hospital (RCCH). Body weight at the time of transfer 37 kg, the child does not need surgical treatment.

After discharge from the surgical department, the child was examined and treated at the RCCH with a diagnosis: “CD: terminal ileitis, complicated by purulent omentitis, serous peritonitis. Condition after surgical treatment: subtotal large omentum resection. Lactase deficiency. Chronic gastroduodenitis, Helicobacter negative, exacerbation period, mixed type of sphincter of Oddi dysfunction. Posthemorrhagic iron deficiency anemia of the 1st degree”. There, the girl received specific anti-inflammatory therapy.

III hospitalization (intestinal obstruction)

After 21 days from the moment of discharge (after re-hospitalization), the girl was again admitted to KODB No. 2 on an emergency basis with complaints of abdominal pain of a cramping character of moderate intensity that arose 12 hours before the visit, a single vomiting. Upon detailed questioning, the girl reported 4 kg weight loss since the second operation, the overall decrease in body mass was 10-11 kg. Moreover, against the background of treatment on the basis of the RCCH, the girl noted frequent vomiting, impaired absorption of food, loss of appetite. On examination, the abdomen was swollen mainly in the lower sections and the umbilical region, on palpation it was soft, moderately painful in all sections. Peristalsis was very sluggish. Postoperative scar without signs of inflammation and ventral hernias, well-to-do. Peritoneal signs were not identified.

Ultrasound of the AO on admission: “Condition after surgery. CD (there is a section of the ileum with a hypoechoic thickened wall up to 9 mm and a collapsed lumen with parietal air bubbles). Signs of intestinal obstruction (loops of the small intestine were expanded to 33-36 mm, filled with echogenic contents, peristalsis could be traced, delayed antegrade one)".

Stimulation of the intestines the patient tolerated satisfactorily without an increase in pain, there was no vomiting, but after setting a cleansing enema, only feces-stained enema waters were obtained.

On the survey radiograph of the AO in dynamics (within 12 hours) after giving a suspension of barium - negative dynamics in the form of an increase in the number and size of Kloyber bowls, the contrast agent was located along the small intestine, without further advance (Fig. 2).

Fig. 2. A series of X-rays of the abdominal organs with oral contrast (barium sulfate): A — plain X-ray upon admission; B — plain X-ray after bowel stimulation; C — plain X-ray one hour after BaSO4 intake; D — plain X-ray image 3 hours after BaSO4 intake; E — plain X-ray 6 hours after BaSO4 intake; F — plain X-ray 12 hours after taking BaSO4

The preliminary diagnosis: CD with lesions of the ileum, adhesions of the abdominal cavity, acute mixed intestinal obstruction. Surgical intervention was indicated: midline laparotomy, revision of the abdominal organs, the volume of the operation will be determined intraoperatively.

On an urgent basis, surgical intervention was performed under endotracheal anesthesia: relaparotomy, revision of the abdominal organs. The loops of the initial parts of the jejunum were slightly widened, soldered together by membranous planar adhesions. The latter were divided. In the zone of transition of the jejunum into the ileum, a dense planar adhesion is determined, forming a "double-barrel" with impaired patency. With further revision of the abdominal cavity, ileal loops swollen to 6 cm are determined. In the lower parts of the abdominal cavity, a significant number of cord-like adhesions are determined, spreading through the loops of the ileum and fixing them, forming multiple "double barrels" with impaired patency. With pronounced technical difficulties, in a blunt and sharp way, the loops of the small intestine of the lower sections were separated from the parietal peritoneum, separated from each other until patency was fully restored. Technical difficulties were associated with the complexity of differentiating adhesions from the tissues of the mesentery of the small intestine and with a very high density of adhesions.

In the right iliac fossa and mesogastrium, a massive adhesion process was determined with the formation of a conglomerate of ileal loops (50 cm from the ileocecal angle), roughly welded together and rigidly soldered to the parietal peritoneum of the right lateral canal and the anterior abdominal wall by dense adhesions. The conglomerate was separated from the parietal peritoneum, brought into the wound. The bowel loops in this zone were infiltrated, hyperemic, over-inflated up to 8-9 cm in diameter, the walls of the intestine at the fusion sites were ischemic, white, their separation was recognized as inappropriate due to the significant risk of organ perforation, peristalsis in this area was not traced, a weak pulsation of the mesenteric vessels was noted. The intestinal wall was modified as a "cobblestone pavement" (Fig. 3).

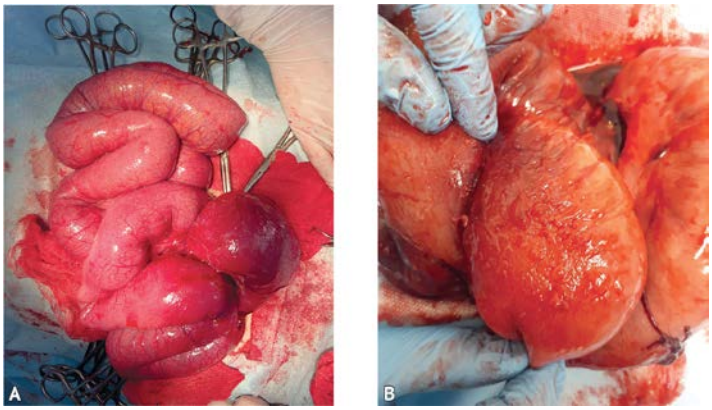

Fig. 3. Alterations of the ileum wall: A — intraoperative photo: the arrow indicates the altered section of the intestine of the “cobblestone” type; B — removed preparation

The revision of the ileum was continued: in its distal sections, at the place of transition to the cecum, a section of the intestine up to 20 cm long was determined, which had an aperistaltic cord of cartilaginous density, the lumen inside which was not palpable, the walls were thickened up to 1 cm. The lumen was palpable, the wall was not visually changed.

Resection of the altered part of the ileum with the imposition of an end ileostomy was performed. The distal ileum was “muffled” by the imposition of a two-row intestinal suture at a distance of 7 cm from the ileocecal angle. The large intestine and other parts of the small intestine were not visually changed. Laparotomic wound was sutured tightly in layers.

The patient was discharged for the outpatient stage with a diagnosis: "CD with lesions of the ileum. Acute mixed intestinal obstruction. Abdominal adhesions. Lactase deficiency. Chronic gastroduodenitis (Helicobacter negative), a period of incomplete remission. Dysfunction of the sphincter of Oddi of the mixed type. Mild normochromic anemia of mixed genesis".

Diagnosis after surgery (confirmed by histological examination of the remote portion of the intestine): “CD with lesions of the distal ileum. Abdominal adhesions. Acute mixed intestinal obstruction".

After 4 months, the planned closure of the ileostomy was performed on the basis of the Russian Children's Clinical Hospital, where the child was hospitalized in a satisfactory condition (weight gain by 5 kg since the last operation).

DISCUSSION

It is difficult to disagree that CD is a disease with an unpredictable course [14]. Until now, the problem of differential diagnosis of CD with acute surgical pathology cannot be considered solved. Despite numerous attempts by researchers to find a solution to this problem, the tactics of a doctor when treating such children in an urgent manner remains insufficiently illuminated. [15]. This complicates the treatment of patients, since it delays the time of making a diagnosis, which allows the pathological process to reach the “point of no return”. First of all, the current situation arises as a result of the lack of alertness of practicing specialists in terms of nonspecific inflammatory diseases of the gastrointestinal tract in children [16].

The case described by us should be considered in stages, according to all episodes of hospitalization of the patient. At the first visit, the girl complained of a mass in the right lateral region of the abdomen, fever, and weight loss. It is the decrease in m.t. the child was prompted by colleagues to think about the presence of a mass, which manifests itself in this way (a tumor of the pelvic organs, pelvic bones, abdominal organs). If we take into account only the presence of a protrusion in this area, then, of course, one should think about any inflammatory process in the soft tissues (but, as mentioned above, the skin in the projection of the formation had not been changed). But, according to all the results of laboratory and instrumental examination, consultations of medical specialists, all these assumptions were not confirmed. Even after analyzing all the patient's complaints and an integrated approach to them (without dividing them), the symptoms and examination results were in favor of sluggish purulent-inflammatory diseases of the AO (for example, an appendicular abscess with the formation of its walls with damage to the muscles that form the frame of the abdominal cavity), requiring surgical treatment. Even following the results of laparoscopy, the diagnosis was doubtful (visually and during traction with instruments, the sections of the intestinal tube were not changed). There are very few reports in the literature on variants of idiopathic torsion of the greater omentum strand without a previous primary AO disease. Note that this active intraoperative tactic (described above) is rarely used, since it can lead to a violation of the integrity of the intestinal wall, the development of peritonitis and the formation of intestinal fistulas in the postoperative period. However, in this case, it can be considered justified due to the need to sanitize purulent foci, which could be opened using endovideosurgical technologies, which in turn made it possible to avoid further destruction of the tissues of the anterior abdominal wall and the adjacent section of the intestinal tube.

However, in the case of a second hospitalization and an operation (already in the traditional open way), the diagnosis was not in doubt - CD (since the area of the ileum of cartilaginous density was determined by palpation).

The subsequent deterioration of the condition (intestinal obstruction against the background of CD) was associated with the progression of the disease, which could be triggered by the performed surgical procedures, which undoubtedly had an effect on the general resistance of the body, homeostasis and the child's immune system. In this connection, in the opinion of the group of authors, the thesis that the awareness of doctors about this disease in determining the diagnostic tactics and the implementation of a sufficient volume of clinical and laboratory-instrumental research methods will speed up the verification of the diagnosis of CD and the appointment of adequate therapy should not be questioned [12, 17].

CONCLUSIONS

1. Thus, the clinical case presented by us clearly characterizes the complexity of the diagnosis of Crohn's disease. Since this disease has a wide range of manifestations due to the non-specificity of the lesion (depending on the location and extent of the lesion of the segments of the intestinal tube) from appendicitis-like symptoms and signs of intestinal obstruction up to the formations of the abdominal cavity (which is the basis for the "atypical" manifestation of the disease in our patient).

2. This work emphasizes the need for an in-depth study of the pathophysiology and etiology of Crohn's disease, it will improve the treatment of this disorder.

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Received on 29.04.2020

Review completed on 16.11.2020

Accepted on 21.12.2020