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IMAGES IN EMERGENCY MEDICINE

Gastrointestinal

Abdominal pain after a food crawl

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1 | PATIENT PRESENTATION

A 28-year-old female presented to the emergency department with a 3-day history of abdominal pain after a food crawl. Her abdomen was significantly distended with a pulse of 120 beats/min and temperature of 37.9°C. She proceeded to leave against medical advice and returned the next day with a taut abdomen and peritoneal signs. Her pulse was 156 beats/min with worsening hypoxia and declining mental status. She was intubated and started on broad-spectrum antibiotics. Computed tomography (CT) imaging was obtained (Figures 1 and 2).

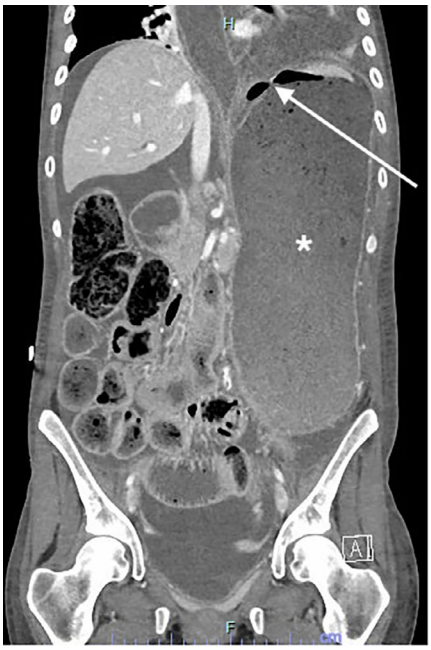

FIGURE 1 A coronal computed tomography image of the abdomen and pelvis with contrast, showing gastric distension (star) with free air under the diaphragm (arrow).

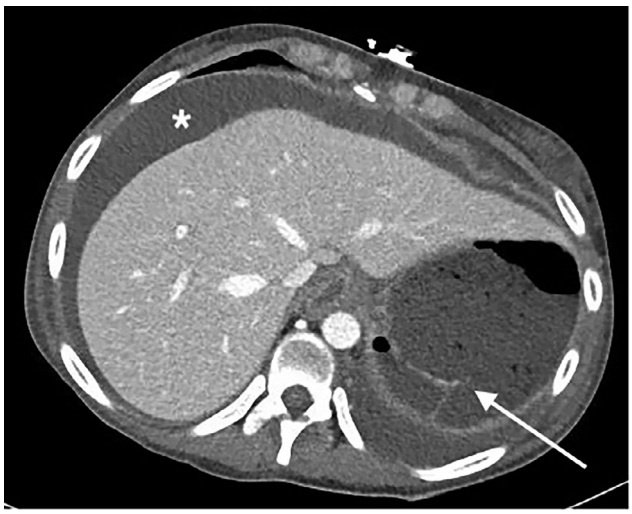

FIGURE 2 An axial computed tomography image of the abdomen with contrast, showing gastric perforation (arrow) and large-volume peritoneal fluid (star).

2 | DIAGNOSIS: GASTRIC PERFORATION

CT revealed gastric perforation with notable free air and abdominopelvic ascites. She was taken to the operating room for an

exploratory laparotomy where an estimated 16L of dense food particles were removed. Her clinical course included a month-long intensive care unit (ICU) stay involving multiple abdominal washouts until her abdomen could be closed.

Bowel perforation is a life-threatening condition, with a mortality rate of 30% despite improved medical and surgical interventions.[1] There are four mechanisms that can lead to bowel perforation: ischemia, infection, erosion, and physical disruption.[2] Mainstays of management remain consistent in the literature, involving hemodynamic management and early initiation of broad spectrum antibiotics, with most cases progressing to surgical exploration and repair.[3]

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

REFERENCES

1. Shin R, Lee SM, Sohn B, et al. Predictors of morbidity and mortality after surgery for intestinal perforation. *Anna Coloproctol*. 2016;32(6):221. doi:10.3393/ac.2016.32.6.221
2. Tanner TN, Hall BR, Oran J. Pneumoperitoneum. *Surg Clin North Am*. 2018;98(5):915-932. doi:10.1016/j.suc.2018.06.004
3. Jones MW, Kashyap S, Zabbo CP. *Bowel Perforation*. StatPearls Publishing; 2023. https://www.ncbi.nlm.nih.gov/books/NBK537224/

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