



10. NAVIGATING THE CHALLENGES OF SHORT BOWEL SYNDROME

Author: Cucu Alexandra-Gabriela

Scientific advisor: Dimofte Mihail-Gabriel, PhD, Professor, The 2nd Surgical Oncology Department of Regional Institute of Oncology, “Gr. T. Popa” University of Medicine and Pharmacy, Iași; Iacob Ștefan, MD, Associate Professor, the 2nd Surgical Oncology Department of the Regional Institute of Oncology, “Gr. T. Popa” University of Medicine and Pharmacy, Iași

Introduction. Short bowel syndrome (SBS) is a rare condition characterized by malabsorption of macronutrients, micronutrients, electrolytes, and water following extensive resection or loss of a significant portion of the small bowel. Managing SBS poses significant challenges, necessitating a multidisciplinary approach. When patients fail to return to an oral diet despite medical therapy, long-term parenteral nutrition becomes essential, accompanied by potential risks such as gallstones, oxalate kidney stones, or steatohepatitis associated with parenteral nutrition.

Case statement. A 44-year-old patient with a history of right colon neoplasm, right colectomy, and enterectomy due to accidental ingestion of a dental prosthesis, presented with recurrent sub-occlusive episodes. These episodes were unresponsive to conservative measures for sub-occlusive syndrome attributed to abdominal adhesions, leading to surgical intervention. Intraoperatively, complex abdominal adhesions and numerous fistulas were discovered, necessitating extensive short bowel resection. Subsequently, anastomotic fistulas occurred, leading to a slow postoperative course with prolonged paralytic ileus. The patient eventually developed an enterocutaneous fistula, externalizing approximately 4000 mL daily for 3 weeks. Conservative management involved parenteral nutrition, targeted antibiotic therapy, GLP-2 analogue and opioid medication to control fistula flow. Despite these efforts, increased fistula output necessitated surgical reintervention, resulting in the creation of an enterostoma, ultimately leading to the development of SBS. The patient faced challenges during hospitalization, including severe nutritional deficits, cachexia, complex nutritional deficits, and pancytopenia, which were managed with granulocyte stimulating factors and repeated transfusions. Although the patient initially responded transiently, he ultimately succumbed to cardiac arrest that was refractory to resuscitation maneuvers.

Discussion. The ideal treatment for this patient would have been a small bowel transplant; however, the oncologic history precluded this option. Small bowel transplant guidelines recommend a progression-free disease interval of 2-5 years, which our patient did not meet, being less than 2 years from diagnosis.

Conclusion. This case highlights the development of short bowel syndrome following multiple surgical interventions for abdominal adhesions, anastomotic leaks, and enterocutaneous fistulas. Managing SBS is intricate, with poor outcomes and high costs if not approached judiciously.