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Situs Inversus Totalis With Portal Hypertension- Surgical Challenge (Case Report)

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Background : Situs inversus totalis is a rare clinical condition where there is complete transposition Right to left of thoracic and abdominal organs in sagittal plane.[1] This anomaly is more commonly seen in males than in females 1.5:1. [2] Assessment of anatomical details in the present era is possible because advances in imaging modalities & So that planning of radiological or surgical intervention may be possible, with safety[3,4]. We present such a challenging case, Situs Inversus totalis in an adult female patient, with cirrhosis of liver with portal hypertension.

Methods : In Surgery Out patient, We reviewed a case of -41yrs.female, farmer, Referred from Medicine, with Situs Inversus Totalis (SIT) - for symptomatic Hypersplenism (Grade 3 splenomegaly) secondary to Portal Hypertension, with one episode of hematemesis. She was on beta blockers. Endoscopic band ligation done- for one episode of hematemesis recently. Umbilicus inverted and transversely placed. Lump visible in right Hypochondrium. Intra abdominal lump- of 10 cm.X10 cm. below Right costal margin. Extending inferiorly into Right lumber and medially up to Umbilicus Regular margins with smooth surface Firm in consistency,non tender. Splenomegaly grade 3.

Results : Gastric Devascularization Proximal two thirds of greater and lesser curve. Porta-Azygous Disconnection at GE Junction with Splenectomy was planned. Pre operative optimization was done Technique- Patient underwent Devascularization with splenectomy as planned Under Intra tracheal GA, Modified Makuuchi Incision - Ascites -750cc. Devascularization – as planned. Intra-op Findings:-Bilobed Spleen, with Separate vessels. spleen adherent to Left lobe of Liver. Spleniculi in the Hilum of Spleen. Liver biopsy was done.

Conclusions : SIT is rare congenital anomaly, and may be Associated with various gastrointestinal (GI) and vascular abnormalities. Because of anatomical abnormalities (Portal venous anomaly, Mirror position of viscera) Surgical or radiological intervention in such patients is a challenge for an interventional radiologist or surgeon, as seen in our patient[6,7]. In our patient, also there was symptomatic hypersplenism and so splenectomy was mandatory, and there was one episode of bleeding. So we preferred Gastric Devascularization and splenectomy. Selection of patient for a definitive surgical procedure is of utmost importance in our case. Our choice of selecting the case for the planned procedure will not interfere with the future definitive procedures for portal hypertension, in this patient.

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