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LEFT SIDED COLO-COLIC INTUSSUSCEPTION: A RARE ENTITY

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ABSTRACT Invagination of one segment of bowel into adjacent segment is known as intussusception. Intussusception is usually seen in paediatric age group. It is rarely seen in adults. Furthermore it is unusual to get an intussusception involving the descending colon. The usual cause of colo-colic intussusception is a malignant lesion acting as lead point. Rarely a benign lesion can act as a lead point. High index of suspicion is required to diagnose intussusception in adults. Contrast enhanced computer tomography (CECT) is a useful diagnostic tool to diagnose intussusception in adults. With growing expertise in field of laparoscopy these cases can be managed laparoscopically. We describe a rare case of colo-colic intussusception involving transverse colon and descending colon in an elderly male, caused by a lipoma acting as a lead point, which was treated by laparoscopic left hemicolectomy. In this article we emphasize on the rare location of intussusception, role of laparoscopy in management of this case and a benign pathology at an unusual location.

KEYWORDS : Colo-colic Intussusception, Laparoscopic Colectomy, Lipoma of colon

Introduction:

Intussusception is defined as invagination of one segment of bowel into the adjacent segment. Incidence of intussusception is more in paediatric age group. They are usually idiopathic. They are primarily managed non-operatively by hydrostatic reduction. In adult population intussusception is less common. When they occur in adults small bowel is the usual site. Caecum and transverse colon have been reported to be involved in intussusception. It is very rare to see intussusception at descending colon. In adults, intussusception is caused due to a lesion acting as lead point. Small bowel intussusceptions are associated with benign lesions being lead points. In colo-colic intussusception lead point is usually formed by a malignant lesion. Rarely benign lesions such as adenomas and lipomas are reported to act as lead point in colo-colic intussusception. Here, we present a case of distal transverse colon to descending colon intussusception with lipoma as lead-point which was managed laparoscopically.

CASE REPORT:

A 51 year old gentleman presented with abdominal pain for 10 days. The pain was gradual in onset, dull- aching and generalized. There was no history of vomiting. He was a known hypertensive, on medication for 1 year. At the time of admission, his blood pressure was 140/70 mmHg, pulse was 74 beats per minute, respiratory rate was 16 breaths per minute and oxygen saturation was 99% at room air. On examination, he had appreciable bowel sounds with a vague lump in left lumbar region and left iliac fossa. Laboratory tests were within normal range. CECT showed long segment intussusception involving distal transverse colon and descending colon with the intussusceptum being distal transverse colon and intussuscipiens being descending colon. The lead point was a submucosal lipoma measuring 6 cm x 3.5 cm. The small bowel was normal in caliber [Fig 1]. Colonoscopy showed colo-colic intussusception. Laparoscopic Left hemicolectomy was performed [Fig 2]. Specimen was delivered out by a small incision [Fig 3]. A large pedunculated lesion was found in distal transverse colon [Fig 4]. On histopathology lesion was confirmed to be a lipoma. The post-operative course was uneventful and he was discharged home after 5 days in stable condition.

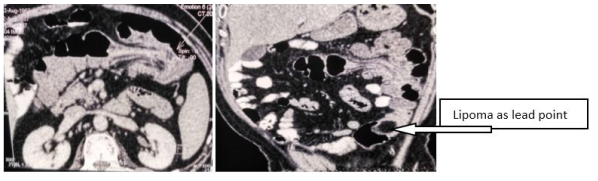


Fig 1: CECT Abdomen



Fig 2: Colo-Colic Intussusception



Fig 3: Laparoscopic left hemicolectomy specimen



Fig 4: Pedunculated lipoma

DISCUSSION:

Intussusception is defined as the invagination of one segment of the bowel into adjacent segment of the bowel. Children with intususseption present with pain in abdomen, palpable mass and red currant jelly stools (1). In children intussusception is usually idiopathic ileo-colic intussusception, managed conservatively with non-operative reduction via pneumatic or hydrostatic enemas. Adult patients of intussusception present with features of intestinal obstruction, however they may also present with non-specific features as pain in abdomen, nausea and vomiting (2). Since they are rare to occur in adults, high index of clinical suspicion is essential. In adult population, intussusception occurs more often in small intestine than in colon. It is caused by a lesion acting as lead point in most cases (3). When adults presents with small bowel intussusception, it is usually due to benign lesion (3-5). In contrast, adult ileocolic and colo-colic intussusceptions, lead point pathology is more frequently malignant (Adenocarcinoma) (5). Rarely benign lesions may be associated with adult colo-colic intussusceptions (lesions being hyperplastic polyps, adenomatous polyps and lipomas). Lipoma in colon is a rare lesion of mesenchymal origin. Most common locations of colonic lipomas are ascending colon and caecum(6). Ultrasound abdomen is usually inconclusive in adult intussusceptions. CECT of abdomen is the gold standard investigation for diagnosis (7). Conventionally they have been managed by open surgery, with colo-colic intussusceptions requiring radical surgery as most of the lead point lesions are malignant in nature (8). With increasing expertise in laparoscopy, these cases can be managed laparoscopically, thus reducing morbidity and facilitating early recovery of the patient.

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