



A CASE OF CECAL ADENOCARCINOMA PRESENTED AS ILEOCOLIC INTUSSUSCEPTION

Prof. Dr. B. Santhi	MS (General Surgery), DGO, Professor and Head of the Department, Department of General Surgery, Government Kilpauk Medical College, Chennai – 600010.
Dr. S. Karthikmuthuram	MS (General Surgery), Assistant Professor, Department of General Surgery, Government Royapettah Hospital, Government Kilpauk Medical College, Chennai – 600010.
Dr. Balaji Kumaravel. S.*	MBBS, Postgraduate in MS General Surgery, Department of General Surgery, Government Royapettah Hospital, Government Kilpauk Medical College, Chennai – 600010. *Corresponding Author

ABSTRACT Intussusception in adults is an infrequent cause of intestinal obstruction. Rarely the lead point of the intussusception is neoplastic lesion. We report a rare case of intestinal obstruction caused by ileocecal intussusception with cecal adenocarcinoma as lead point.

KEYWORDS :

INTRODUCTION & BACKGROUND:

Intussusception occurs when a proximal segment of intestine invaginates into a distal segment or vice versa, a potential cause of obstruction. This can subsequently compromise the blood supply and trigger intestinal ischemia, infarction, or perforation. Intussusception is a common cause of intestinal obstruction in children but is rare in adults.

CASE REPORT:

A 41 year old male patient presented to casualty with complaints of abdominal pain for 2 days associated with multiple episodes of non-projectile vomiting containing food particles ,along with history of abdominal distension and obstipation.

On examination no tachycardia,diffuse distension of the abdomen was noted. Diffuse tenderness and guarding was present over the abdomen. Bowel sounds sluggishly heard. Pre rectal examination revealed collapsed rectum with no fecal staining.

X ray abdomen erect showed multiple air fluid levels(Fig. 1). CECT abdomen and pelvis showed Ileocolic Intussusception (Fig. 2).



Fig. 1: CXR & x-ray abdomen erect (showing multiple air fluid levels)

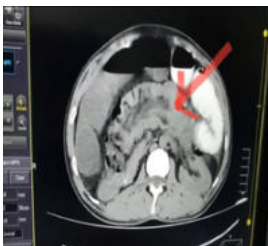
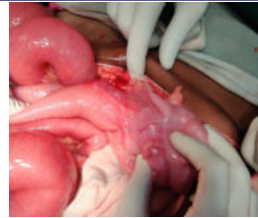


Fig. 2: CT abdomen showing ileocolic intussusception



Patient was taken for emergency laparotomy and found to have cecal growth as the lead point of Intussusception. Patient was proceeded with Right Hemicolectomy with side to side Ileotransverse anastomosis.



Fig. 3: Intraop findings and Post operative specimen showing Cecal Growth

The Histopathology revealed as Moderately differentiated Adenocarcinoma of cecum(6*6*2.5cm) (Fig. 4)

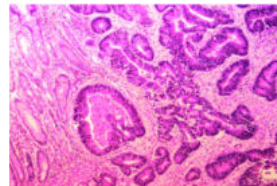


Fig. 4: Histology of moderately differentiated adenocarcinoma of cecum

DISCUSSION:

Only about 5% of intussusceptions causing intestinal obstruction occur in adults. There are multiple types of intussusception, such as gastro-duodenal, jejun-jejunal, ileo-ileal, ileo-colic, and colo-colic. In children, 90% of the intussusceptions are ileo-colic and idiopathic. In a recent study with 148 adults, 80% of the cases were enteric

intussusceptions. In adults, 80% of the intussusceptions are secondary to a pathologic process such as tumors, suture lines, or adhesions. Benign or malignant tumors act as a lead point in 65% of reported adult cases. Most of the adult colocolic intussusceptions are due to malignancy, such as primary adenocarcinoma of the colon, as in our patient.

The most common symptoms of intussusception in adults are abdominal pain, nausea, and vomiting. Physical exam rarely discloses an abdominal mass. Plain films usually show intestinal obstruction. CT scan is the most sensitive diagnostic tool due to the pathognomonic target sign and sausage-shaped appearance. In a recent study by Lindor et al, 93% of the adults with intussusception had a positive CT scan. Even though CT scan diagnoses the intussusception, the etiology is rarely identified. Sonography also can be useful in diagnosing intussusception by revealing a target or doughnut sign in transverse view, but this can be limited by obesity or the presence of distended bowel loops. A recent retrospective review by Honjo et al showed that ultrasonography had an accuracy of about 50% in the preoperative diagnosis of adult intussusceptions.

The treatment for intussusception varies greatly among children and adults due to the different etiologies. In children, the treatment of choice involves reduction of the intussusception with hydrostatic or pneumatic enemas since most are idiopathic in nature. Adults usually present with nonspecific symptoms, and diagnosis can be difficult. When preoperative diagnosis is established in adults, reducing the intussusception is controversial due to the high incidence of malignancy, which can result in perforation, dissemination of microorganisms and malignant cells into the peritoneal cavity, and anastomotic complications of the edematous and inflamed bowel. For these reasons, most authors recommend resection of the affected bowel to either prevent recurrence or provide cure, since more than 65% of the adults have a malignant lesion as the lead point. Recent studies have proposed preoperative reduction in certain patients with nonischemic small bowel intussusceptions secondary to benign disease. Preoperative reduction permits a more limited resection, in contrast to primary en bloc resection, which is not ideal in patients at risk of short gut syndrome.

REFERENCES

1. Lindor RA, Bellolio MF, Sadosty AT, Earnest F, 4th, Cabrera D. Adult intussusception: presentation, management, and outcomes of 148 patients. *J Emerg Med.* 2012;43(1):1-6. [PubMed] [Google Scholar]
2. Namikawa T, Okamoto K, Okabayashi T, Kumon M, Kobayashi M, Hanazaki K. Adult intussusception with cecal adenocarcinoma: successful treatment by laparoscopy-assisted surgery following preoperative reduction. *World J Gastrointest Surg.* 2012;27(45):131-134. [PMC free article] [PubMed] [Google Scholar]
3. Onkendi EO, Grotz TE, Murray JA, Donohue JH. Adult intussusception in the last 25 years of modern imaging: is surgery still indicated? *J Gastrointest Surg.* 2011;15(10):1699-1705. [PubMed] [Google Scholar]
4. Traoré D, Sissoko F, Ongoiba N, Traoré I, Traoré AK, Koumaré AK. Adult intussusception: diagnostic pitfalls, morbidity and mortality in a developing country. *J Visc Surg.* 2012;149(3):e211-e214. [PubMed] [Google Scholar]
5. Minaya Bravo AM, Vera Mansilla C, Nogueales Fraguas F, Granell Vicent FJ. Ileocolic intussusception due to giant ileal lipoma: review of literature and report of a case. *Int J Surg Case Rep.* 2012;3(8):382-384. [PMC free article] [PubMed] [Google Scholar]
6. Alvarez FA, Nicolás M, Goransky J, Vaccaro CA, Beskow A, Cavadas D. Ileocolic intussusception due to intestinal metastatic melanoma. Case report and review of the literature. *Int J Surg Case Rep.* 2011;2(6):118-121. [PMC free article] [PubMed] [Google Scholar]
7. Brayton D, Norris WJ. Intussusception in adults. *Am J Surg.* 1954;88(1):32-43. [PubMed] [Google Scholar]
8. Azar T, Berger DL. Adult intussusception. *Ann Surg.* 1997;226(2):134-138. [PMC free article] [PubMed] [Google Scholar]
9. Marinis A, Yiallourou A, Samanides L, Dafnios N, Anastasopoulos G, Vassiliou I, Theodosopoulos T. Intussusception of the bowel in adults: a review. *World J Gastroenterol.* 2009;15(4):407-411. [PMC free article] [PubMed] [Google Scholar]
10. Gayer G, Hertz M, Zissin R. CT findings of intussusception in adults. *Semin Ultrasound CT MR.* 2003;24(5):377-386. [PubMed] [Google Scholar]
11. Honjo H, Mike M, Kusanagi H, Kano N. Adult intussusception: a retrospective review. *World J Surg.* 2015;39(1):134-138. [PMC free article] [PubMed] [Google Scholar]