



A RARE CASE OF COLO-COLIC INTUSSUSCEPTION IN AN ADULT

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ABSTRACT

Introduction: Intussusception is telescoping or invagination of one portion (segment) of bowel into adjacent segment. Intussusception in adults accounts for 5% of all intussusception. Adult intussusception is usually secondary to an identifiable cause like malignant or benign neoplasms, polyps, Meckel's diverticulum, postoperative adhesions. Association with malignant tumors is more common in large bowel intussusception than small bowel. In adults, intussusception presents with vague abdominal symptoms hence diagnosis becomes difficult. CT is the most effective diagnostic modality. Treatment in adults is usually exploratory laparotomy with surgical resection.

KEYWORDS : Intussusception, obstruction, resection, anastomosis.

INTRODUCTION

Intestinal intussusception in adults is uncommon, accounting for about 5% of all intussusceptions and representing only 1% of intestinal obstructions(1–4). Unlike pediatric intussusception, which is usually idiopathic, adult intussusception is most often secondary to an identifiable cause(1–4). Many pathological conditions like malignant or benign neoplasms, polyps, Meckel's diverticulum, and postoperative adhesions, may act as lead point(1,3,4). Association with malignant tumors is more common in large bowel intussusception (65–70% of cases), while small bowel intussusceptions are secondary to a malignancy in 30–35% of cases only(1). Colocolic intussusception in adults is the least prevalent accounting only 8-19%. Colocolic intussusception is more commonly associated with a malignant lead point (65%). In adults, intussusception is more likely to present insidiously with vague abdominal symptoms and rarely presents with the classic triad of vomiting, abdominal pain and passage of blood per rectum, making diagnosis difficult(5–7). CT findings are pathognomonic for intussusception, making CT the most effective diagnostic test(1,5,7). In contrast to pediatric intussusceptions, which are managed nonoperatively with air contrast enemas, treatment in adults is exploratory laparotomy for surgical reduction or resection(3,6–8).

Case Report

A 17 years old male came with complaints of abdominal pain, vomiting, constipation for 2 days. On examination abdomen was soft, tenderness present over the epigastric, umbilicus and left lumbar region. CECT abdomen and pelvis showed colocolic intussusception with target sign.



Fig.1 Showing Target Sign In Cect Abdomen

have colocolic intussusception with invagination of caecum and ascending colon into transverse colon.



FIG.2 Showing invagination of caecum and ascending colon into transverse colon

Reduction done then apex was found to be caecum with lead point in it. Hence proceeded with resection of terminal ileum and caecum with side to side anastomosis of ileo-ascending colon. HPE report came out to be a inflammatory caecal polyp.

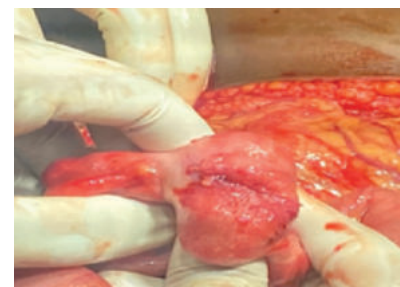


FIG.3 showing lead point in caecum



FIG.4 Showing caecal polyp

Patient was taken up for emergency laparotomy and found to



FIG.5 Showing resected specimen of terminal ileum with caecum and appendix

DISCUSSION

Intussusception is telescoping or invagination of one portion (segment) of bowel into the adjacent segment(1,9–11). It usually begins in the region of the terminal ileum, and extends distally into the ascending, transverse or descending colon. Rarely, an intussusception may prolapse through the rectum(12). Types include ileocolic (most common), ileoileocolic, ileoileal, Colocolic, multiple. It is most common in children, with a peak incidence between 5 and 10 months of age. It is the commonest cause of intestinal obstruction in children(9–11).

About 90% of cases are idiopathic but an associated upper respiratory tract infection or gastroenteritis may precede the condition(10,11). One hypothesis suggests that hypertrophy of the Peyer's patches in the terminal ileum from an antecedent viral infection acts as a lead point(12). In older children, the incidence of a pathologic lead point is 12%, and Meckel's diverticulum is the most common lead point for intussusception. Other causes include intestinal polyps, inflamed appendix, submucosal hemorrhage associated with Henoch- Schönlein purpura, foreign body, ectopic pancreatic or gastric tissue, and intestinal duplication(10).

Symptoms include abdominal pain, vomiting, passage of bloody mucus (currant jelly stool), and a palpable abdominal mass(10). On examination, an elongated mass is detected in the right upper quadrant or epigastrium with an absence of bowel in the right lower quadrant (Dance's sign)(12). Plain X-ray abdomen shows multiple air fluid levels. CT scanning is the most sensitive radiological method to confirm intussusception. Barium enema shows typical claw sign or coiled spring sign (Pincer end). Ultrasound

shows target sign or pseudo kidney sign or bull's eye sign, which is diagnostic. Doppler may show mass with doughnut sign and is useful to check blood supply of bowel(9–11).

Hydrostatic reduction by enema using contrast material or air is the therapeutic procedure of choice. Contraindications include the presence of peritonitis and hemodynamic instability. The recurrence after hydrostatic reduction is approximately 11%, and it usually occurs within the 24 hours after the reduction. When it recurs, it is usually managed by another air enema reduction. A third recurrence is an indication for operative management(9,10). Reduction is achieved by gently compressing the most distal part of the intussusception toward its origin. After reduction, viability of the bowel is checked(9,11). Bowel resection is required in cases in which the intussusception cannot be reduced, the viability of the bowel is uncertain, or a lead point is identified(10).

CONCLUSION

Colo colic intussusception being a rare entity in adults early diagnosis and timely intervention is required in all the cases to

avoid unnecessary complications. CT remains the diagnostic modality of choice. Emergency laparotomy with en bloc resection remains mainstay of treatment as most cases are associated with a lead point in it.

REFERENCES

1. Viola Valentini. Intussusception in Adults: The Role of MDCT in the Identification of the Site and Cause of Obstruction.
2. Taraneh Azar. Adult Intussusception.
3. Athanasios Marinis. Intussusception of the bowel in adults: A review. Available from: <http://www.wjnet.com/1007-9327/15/407.asp>
4. Adult Colocolic Intussusception and Literature Review.
5. Kris P. Intussusception in adults.
6. Teng Lu. Adult Intussusception.
7. Bowel intussusception in adult: Prevalence, diagnostic tools and therapy.
8. Savas Yakan. Intussusception in adults: Clinical characteristics, diagnosis and operative strategies.
9. SRB MANUAL OF SURGERY.
10. Sabiston DC, Townsend CM, Beauchamp RD, Evers BM, Mattox KL, editors. Sabiston textbook of surgery: the biological basis of modern surgical practice. 20th edition. Philadelphia, PA: Elsevier; 2017. 2146 p.
11. Bailey & Love's Short Practice of Surgery, 27th Edition: The Collector's edition [Internet]. CRC Press; 2018 [cited 2022 Nov 4]. Available from: <https://www.taylorfrancis.com/books/9781315111087>
12. Brunnicardi FC, editor. Schwartz's principles of surgery. Eleventh edition. New York: McGraw-Hill; 2018