



Caeco-Colic Intussusception in Adult Mimicking Appendicular Mass- A Case Report

KEYWORDS

Intussusception, Appendicular mass, Right hemicolectomy, laparotomy

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ABSTRACT

Intussusception is not a common encounter in adults. Its diagnosis can be delayed because of its long standing and non specific symptoms and most of the cases are diagnosed on emergency laparotomy. Here we present a case of 54 years old male who was previously diagnosed an appendicular mass, revealed caeco-colic intussusception at emergency laparotomy.

BACKGROUND

Appendicular lump is a common presentation encountered in emergency. There is a established trend to treat the Appendicular mass conservatively which may be adequate in children but in adults one has to be very specific regarding diagnosis. The clinical diagnosis should be confirmed by C.T. abdomen as other pathological conditions such as Intussusception, tumour, lymphoid hyperplasia may simulate an Appendicular mass. Here we present a case of caeco-colic intussusception presenting similar to an Appendicular mass.

CASE REPORT

A 54 year old male presented in the Surgery emergency with complaint of colicky abdominal pain with anorexia and occasional vomiting since 5 days. Pain was more at right iliac fossa and it gradually got worsened. On examination he was afebrile with a pulse rate of 90/min, blood pressure of 110/84mmHg and respiratory rate of 16. The abdomen was slightly distended with guarding and tender palpable mass in right iliac fossa. The rectal examination did not reveal any abnormality.

The haemoglobin was 11gm/dl, WBC $11.6 \times 10^9/L$, neutrophil $8.5 \times 10^9/L$. blood sugar 108mg/dl in fasting state. His liver functions were normal. He was nonreactive to HIV, Hepatitis B, Hepatitis C. Blood urea and serum creatinine were within normal range. The abdominal and chest X-ray were normal.

A provisional diagnosis of Appendicular mass was made. He was managed conservatively with intravenous fluid, broad spectrum antibiotics and analgesics. On the next morning we got the ultrasound report which was in favour of Appendicular mass. Patient was doing well. After a week in the morning patient developed intense pain abdomen and he told that he had similar attack of pain in the last evening and he was about to die. The patient was immediately shifted to operation theatre and he went an emergency laparotomy, which revealed intussusception of caecum into ascending colon with some peritoneal collection. A limited right hemicolectomy was performed with primary ileocolic end to end anastomosis. The post-operative recovery was uneventful. He was discharged after stitch removal. The histology confirmed adenocarcinoma of caecum.

DISCUSSION

Appendicular mass is caused by inflammation of appendix, caecum, omntum and distal part of terminal ileum. The spectrum of disease ranges from appendiceal phlegmon to an appendicular abscess. Usually there are three approaches to the treatment- conservative, immediate drainage of pus in case of Appendicular abscess and interval appendicectomy after resolution in 6-8weeks.

Malignant or benign lesion in the caecum can mimic appendicular mass, such as illustrated by our case. Hence the need to adequately confirm the diagnosis by C.T. Scan at the time of admission is of great importance because it may necessitate an immediate operative intervention. Lipoma is the commonest mesenchymal benign tumour of colon, although rare, accounts for 21% of colonic intussusception.

The majority of intussusception in children, 85-90% is of idiopathic causes. But in adults an identifiable lesion is seen in 90% of cases, about 50% of which may be malignant. Intussusception is not a common encounter in adults, representing 5% of all intussusception and 1% of all bowel obstruction. Patient usually presents with vague abdominal pain and features of partial bowel obstruction which may be acute, intermittent or chronic, with about 11% presenting with an abdominal mass. CT Scan is the most reliable investigation. It is described as a "target mass" on CT Scan with intussusception forming the centre and the oedematous intussusception forming the external ring. Delay in the treatment case lead into full blown bowel obstruction and strangulation.

Treatment of colonic intussusception in adult is en bloc resection, without manipulation, as this prevents perforation of gut or dissemination of malignant cells when the intussusception is malignant.

CONCLUSION

In making a diagnosis of Appendicular lump, adequate investigation such as abnormal CT Scan should be done to rule out other possible causes. Malignant or benign lesion in the terminal ileum and the caecum such as adenoma, adenocarcinoma, lymphoid hyperplasia or lipoma, causing intussusception can mimic Appendicular mass such as illustrated by our case. So once the diagnosis is made by radiological investigation such as abdominal CT Scan at the same admission, an immediate operative intervention may save the life of the patient.

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