Research Paper

Volume : 3 | Issue : 12 | December 2014 • ISSN No 2277 - 8179

Small bowel Intussusceptions due to Benign intraluminal Lesions - 2 Case reports.

Medical Science

KEYWORDS : Intussusception, lead points, Lipoma, fibrous polyp

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ABSTRACT

Intussusception is more common in Children & infants. Intraluminal benign lesions act as a lead point causing intussusceptions in elderly.

Two cases of small bowel intussusceptions were presented in this article as they were noticed in elderly female patients and they were managed without small bowel Resection.

Introduction:

Ileo-colic intussusceptions are most common (75%), and colo-colic, ileoileocolic types *are* rare. Jejuno-jejunal intussusception is very rare. Intussusception is the common cause of small bowel obstruction in children of 6-18 months of age, common in weaning period of a child (common in males).

Causes of intussusceptions include-Change in diet during weaning, upper respiratory tract viral infection, Intestinal polyps, Sub mucous Lipoma, Leiomyoma of intestine, Meckel's diverticulum, Carcinoma, Purpuric sub mucosal hemorrhages.

Red currant jelly is not commonly observed in Intussusception in adult, but it may occur. Clinically adult patients can present with intermittent abdominal pain with or without vomiting, classical Signe De dance may be absent. Imaging in a case of intussusceptions like Barium enema shows claw sign, coiled spring sign. USG- shows Target sign or pseudo kidney sign or bull's eye which is diagnostic. Doppler- shows mass with **doughnut sign** and mesenteric blood supply in the layers of intussusceptions. CECT of the abdomen is more diagnostic in detecting lead point in such patients.

Case 1

A 60 year old female patient was admitted on 11/9/2013 to surgical ward with on & off h/o colicky upper abdominal pain which was increasing after food intake and relieving after half an hour. Patient had nausea & dyspepsia, but there was no h/o

blood stained stools. She was on regular oral antidiabetic drugs since 2 years. On examination pt was moderately built and nourished with pulse-72 beats/min,

BP-160/100mmHg, pallor++, Abdominal examination revealed mild tenderness in the right hypochondrium and epigastrium.There was no distension of the abdomen & no mass was palpable. Her Hb% was 6.1g%, TC-6100 cells/cumm, ESR-125mm/hr ,FBS-162mg%, with normal abdominal X-ray.Ultrasonography of the abdomen showed small bowel intussusceptions due to a hyperechoic mass lesion in the intussusceptum,? Lipoma acting as a lead point, with cystitis.& suggested CECT. Abdominal CECT revealed jejuno-jejunal intussusceptions with jejuna lipoma as the lead point.(Fig-1)

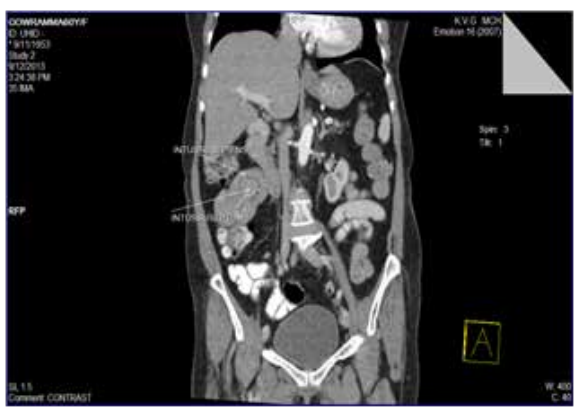

Fig : 1 – CECT showing jejunojejunal intussusception. Following 3 units of Blood transfusion patient was operated & on exploratory laparotomy

the proximal portion of the jejunum was telescoping into the distal jejunum with dilatation of proximal loops. Gentle manual reduction revealed palpable intraluminal mass of about 8X3 cm size.This elongated benign looking lesion was excised by enterotomy and jejunal wound was closed in layers.Resection was not performed. (Fig-2)

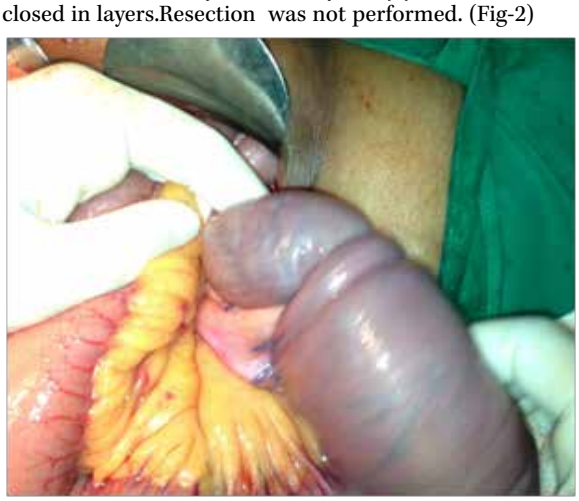

Fig:2 - Per-opertive image showing intussusception.

HPE of the Specimen (fig: 3) consisted of features of Lipoma

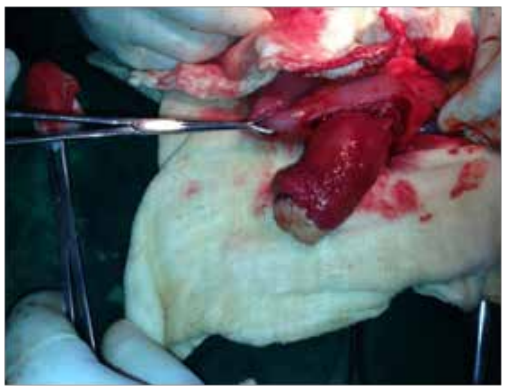

Fig: 3 – Enterotomy showing elongated intraluminal lipoma as a lead point .

Case-2

An 82 years elderly female Hypertensive patient was admitted on 29/6/2014 with h/o colicky pain in the lower abdomen since 3 days. She gave h/o vomiting of yellow color fluid with constipation for 1 day. On examination her BP was-140/80mmHg, pulse-117beats/min, she was afebrile. On palpation her abdomen was soft with tenderness in the right iliac fossa, there was no mass felt. Bowel sounds were increased. Provisional diagnosis of sub acute small bowel obstruction was made. Investigations – Blood –TC-16910cells/cumm, DC-N-77%, L-17%, and E-2%, M-4%, Her RBS& serum electrolytes were within normal limits. Abdominal Ultrasonography& Contrast CT abdomen showed ileoileal Intussusception. On exploration the intussusception was reduced spontaneously, there was an elongated firm intraluminal mass was palpable in the intussuscepted part of the bowel. The lead point was delivered through an enterotomy incision (Fig-a) & 6X2cm elongated polyp like lesion was excised. The enterotomy wound is closed.

Fig-a: intraluminal fibrous polyp delivered through enterotomy.

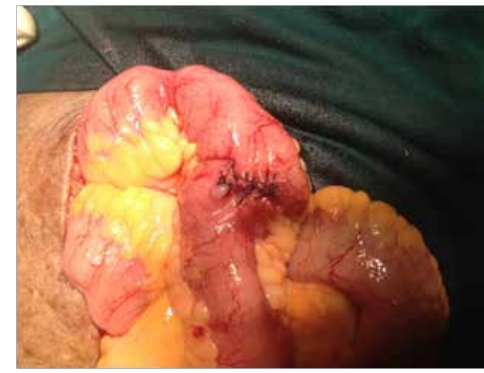

Fig-b: enterotomy closed transversely.

HPE -showed polypoidal lesion displaying features of inflammatory polyp (4x2.5x1cm).

Discussion:

The most common pathological lead point in ileoileal intussusceptions of children is Meckel's diverticulum. Jejunojejunal intussusception is rare & in our patient (Case-1) the sub mucosal lipoma was the lead point. In case2 the intraluminal fibrous (inflammatory) polyp was the lead point. Colicky abdominal pain without previous abdominal surgery should arise suspicion on intussusception. Ultrasonography & CECT of abdomen (58%-100% diagnostic accuracy) shows target sign which is pathognomonic. If there is no signs of bowel ischemia, the the benign lead point can be excised by enterotomy.

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