Research Paper

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Jejunal Pancreatic Choristoma Leading To Small Bowel Intussusception- A Rare Entity

Medical Science

KEYWORDS : Pathological lead point Heterotopia Pancreatic choristoma Small bowel intussusception

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ABSTRACT

Choristoma is congenital anamoly which may go even asymptomatic throughout lifetime.35 years old male presented with clinical picture of acute abdomen whose radiological workup was suggestive of small bowel mechanical obstruction. Surgical exploration revealed jejunal lesion, probably acting as a PLP (pathological lead point) for the jejunojejunal intussusception. Patient was treated with wedge resection of the jejunal lesion and jejunojejunal end to end anastomosis. Histopathological report of the resected specimen was "jejunal pancreatic choristoma ".Jejunal pancreatic choristoma leading to intussusception is exceptionally rare presentation. Hence we emphasize the rarity of occurrence of the condition.

INTRODUCTION:

Bowel intussusception due to hypertrophied peyer's patches is usual surgical presentation in infancy during period of weaning. In adults, occurrence of bowel intussusception should alarm surgeon for presence of any growth, most commonly. Usually intraluminal, intramural growths act as a pathological lead point. Intramural heterotopia i.e. choristoma can play the same role. Pancreatic choristoma is found in jejunum (46.7%)[6], stomach, duodenum, ileum, gall bladder. Among symptomatic heterotopias, small bowel intussusception is rare presentation[2,3,4].

CASE REPORT:

35 years old male presented to casuality with symptoms suggestive of acute abdomen. Patient gave history of generalised colicky pain in abdomen, since past 9 hours; history of 2 episodes of non-projectile bilious vomiting, in past 6 hours. There was no other significant past history like abdominal distention, any defaecation or micturition related complaints, history of hematemesis or blood in stools, history of fever.

On examination, patient was afebrile, having tachycardia, with normal blood pressure and respiratory rate. Per abdomen examination revealed generalised distention of abdomen, with no free fluid and no palpable lump or organomegaly, presence of generalised tenderness and guarding, absence of bowel sounds in all quadrants. Per-rectal examination revealed no tenderness, empty rectum and anal canal, no boggy sensation in cull-de-sac.

X ray erect abdomen showed no abnormality.

Ultrasound of abdomen was suggestive of 'target sign' probably due to small bowel intussusception with to and fro peristalsis of the proximal bowel with no other abnormalities detected.

Complete blood count and serum electrolytes were within normal limits.

Exploratory laparotomy was done with midline laparotomy excision. On surgical exploration, the only abnormality detected was intramural, 2*1 cm, non-ulcerated and non-inflammed, yellowish, mid jejunal lesion, on its' anti-mesenteric aspect. Surgical correction was done with wedge resection and end to and jejunojejunal anastomosis.

Post-operative course went uneventfully.

The surgical specimen showed normal exocrine pancreatic tissue harboured in full thickness of normal jejunum which is suggestive of "pancreatic heterotopia", in this case, "pancreatic choristoma".

DISCUSSION:

Intussusceptionis invagination or telescoping of one portion of bowel into adjacent bowel. There are two types-antegrade and retrograde, among which antegrade is commoner. In adults, colocolic is the commonest site for which growth in the bowel is the commonest cause. For such cases, hydrostatic reduction does not have any role in management.

Table 1. Causes of small and large bowel intussusception[5]

CAUSE	COLONIC INTUSSUSCEPTION	SMALL BOWEL INTUSSUSCEPTION
Malignant tumors (eg. Carcinoid, adenocarcinoma, lymphoma)	48%	17%
Benign tumors (eg. Leimyomas, pancreatic heterotopias)	21%	40%
Other causes (eg. Idiopathic, postoperative)	31%	43%

Klob first described the histological appearance of a heterotopic pancreas in 1859[4]. The estimated occurrence of heterotopic pancreas is one per 500 upper abdominal operations and upto 5% in autopsy cases[4]. During embryological development, if either of dorsal or ventral diverticulum remains in the bowel wall, it grows as a heterotopia, called as "choristoma" when normal histologically and not in anatomic continuity with organ of origin.

Although there are conflicting reports in the literature, approximately half of cases of small bowel HP (Heterotopic Pancreas) are asymptomatic[4]. Intussusception caused by HP is rare but has been described previously.

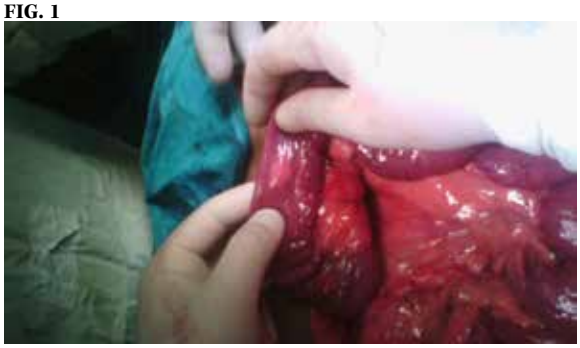
Choristoma is presence of histologically normal tissue at abnormal site and not in anatomic continuity with the original organ. Choristomas can be gastric, pancreatic, thyroid etc.Choristoma can be solitary or multiple. Also it can be symptomatic or asymptomatic. Pancreatic choristoma is found in jejunum (46.7%)[6], duodenum, ileum, in gall bladder (only 2 reported cases till now)[1]. It can present as bowel perforation, acute pancreatitis, as an intussusception very rarely[2,3,4]. If it presents as one of these complications, corrective surgery is performed. If found accidently, resection of tissue bearing region is recommended.

Our case, young male presenting as acute abdomen was found to have intramural jejunal lesion measuring 2* 1 cm on anti-mesenteric aspect when explored surgically. Patient was treated with wedge resection of the jejunal lesion and end to end jejuno-jejunal anastomosis. Histopathological report of the resected speci-

men was " jejunal exocrine pancreatic choristoma".

Patient's post-operative course was uneventful.

FIG. 1



INTRA OPERATIVE PICTURE SHOWING INTRAMURAL JEJUNAL LESION

Conclusion:

The case highlights the rarity of occurance of such presentation and importance of corrective surgery in patient's cure from this pathology. Unlike usual causes of intussusception in adults like colonic growth, this case does not need regular post-operative follow up, chemotherapy or any complex issues. It also highlights that whenever encountered; whether uncomplicated or complicated; heterotopic tissue should be excised to prevent future complications.

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