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Chronic Ileo-Colic Intussusceptions Due To Adenocarcinoma of Colon: A Case Report

Medical Science

KEYWORDS : - Chronic intussusception, adenocarcinoma.

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ABSTRACT

Chronic intussusception is defined as intussusception which continuing over 14 days.

Adult patients represent 5% of all intussusceptions. In adults, 90% cases are caused by well-established pathologic Mechanisms, such as carcinoma, polyps, Meckel's diverticulum, stenosis or neoplasms.

Intussusceptions of small intestine are more common than colonic Intussusception. 50% colonic intussusceptions are caused by malignant neoplasm, especially adenocarcinoma.

We had a 40 years old female patient with of chronic ileocolic intussusceptions.

Right hemicolectomy with ileo- transverse anstomosis was performed, histological examination of the resected specimen revealed the adenocarcinoma of ascending colon.

Case report:

A 40 year old female was referred to our hospital with complaint of pain in the abdomen, anorexia and loss of weight since 1year. Her abdominal pain was mild, intermittent, colicky and nonradiating. She also had per rectal bleeding since 5 months. No history of vomiting or distension of abdomen was reported. On admission she was vitally stable. On abdominal examination app. 8x5x5 cm non tender, mobile lump was palpable in the right lumbar region.

Ultrasonography of the abdomen is suggestive of a psuedokidney sign at right hypochondriac region, indicating the presence of intussusception. Computed tomography (CT) also showed ileocolic intussusception with app. 8x6x5 cm soft tissue mass within the ascending colon with no signs of acute obstruction. We concluded that these symptoms were due to chronic obstruction. Therefore Exploratory Laparotomy was performed, attempt of manual reduction fail. The mesentery and proximal ileum was thickened and edematous. Right hemicolectmy with ileotranseverse anastomosis was performed. Postoperative course of the patient was uneventful; patient discharged on 7 th post-op day and adjuvant chemotherapy was given.

Figure 1: CT Scan showing ileocolic intussusception.

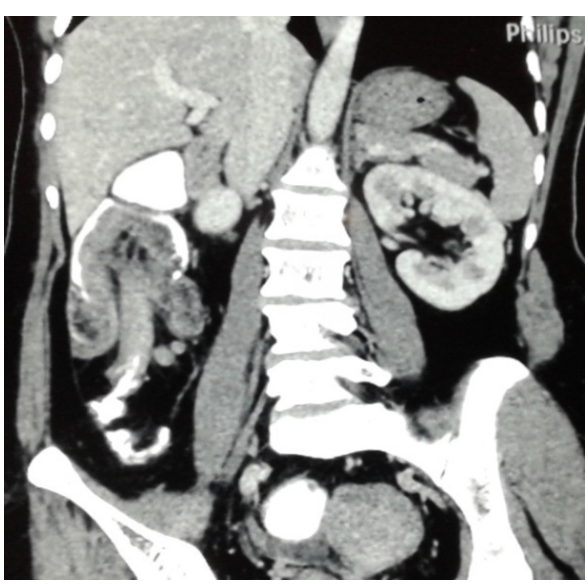
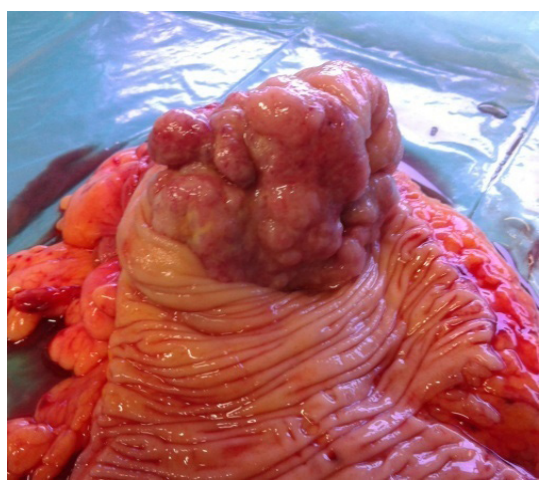


Figure 2: Resected specimen showing intussusceptions.



Discussion:

The prolapse of one segment of the gastrointestinal tract into the lumen of an adjacent segment is referred as intussusception. Commonly proximal segment invaginate into the distal segment but vice versa is possible and known as retrograde intussception. [1] The proximal segment is known as the intussusceptum, and the distal segment is known as the intussuscipiens. The aetiopathology of intussusception is not well understood In contrast to the situation with children, the aetiological factors in adults are known in 80-90% of cases. In 50-60% of all cases of colocolic intussusception aetiology is malignancy. [2, 3] Intussusceptions which involve the small intestine are more frequent, and 90% of the causes involve polypoid lesions such as adenoma, leiomyoma, haematoma, tuberculosis and Meckel's diverticulum. Malignant causes of small bowel intussusception are rare and include primary or metastatic tumours. It is rare in adults; consist of 0.02-0.03% of all cases which reported in the hospital and 1-3% of all cases of surgical intestinal obstructions. [1, 4] Evaluation of previous studies has shown that the median age for intussusception varies between 45 and 57 years. [3, 5] Intussusceptions frequently presents with acute abdominal pain, nausea, vomiting and high WBC count. However, it may present as a sub acute or chronic intestinal obstruction.

USG is frequently employed for the diagnosis of intussusception. Target sign suggest the diagnosis of intussusception. [6] Despite its high sensitivity and specificity due to bowel wall oedema and presence faeces in the colon the rate of a correct diagnosis using USG decreased to 30-35%.

[7, 8] Presence of acute obstructive symptoms and air fluid levels decrease the reliability of USG. [2, 8] CT-scan is the investigation of choice for the diagnosis of intussusception. CT scan may provide sufficient information about lymphadenopathy, metastasis, free fluid and proximal dilation of bowel. [9, 10, 11]

The definitive treatment of intussusceptions in adults is surgical. Hydrostatic reduction may provide successful treatment in cases where bowel viability is not compromised. However, these procedures may lead to perforation of bowel in cases of inflamed, ischemic intussusceptions. Colonic intussusception may cause the spread of tumour cells. In such situation, segmental resection of the involved bowel segment with resection anastomosis is preferred. [12]

Conclusion:

Intussusception is rare in adult patients and it is clinically presents as a sub-acute or chronic intestinal obstruction. This requires a high clinical suspicion; they commonly associated with the pathological lead point. CT scan is the most useful diagnostic tool. An attempt to perform non surgical reduction in small intestinal intussusceptions is possible in Adults, however in ileocolic or colonic intussusceptions, resection of the segment of bowel is recommended.

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