



DESCENDING COLO-COLIC INTUSSUSCEPTION WITH INTRAMURAL LIPOMA AS A LEADING POINT IN AN ADULT – CASE REPORT AT TERTIARY CARE CENTER.

General Surgery

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ABSTRACT

Background: Adult intussusception is uncommon; it accounts for only 1% to 5% of all intestinal blockages and 5% of all intussusceptions. Unlike juvenile intussusception, which is idiopathic in 90% of instances, seventy to ninety percent of adult intussusceptions have an identifiable lead point. Unlike toddlers, who lack distinct pathological lead points, adults typically have a lead point, or recognizable pathological abnormality, that causes the majority of intussusceptions. Unlike childhood intussusception, adult intussusception is linked to malignant lesions, especially in the large bowel as opposed to the small bowel. **Case Summary:** A 55 year old hindu married female patient home maker residing at surat coming from lower socioeconomic class presented in emergency at New Civil Hospital, Surat with complaining of Abdominal pain with fullness for 7 days with not passing of stool for 5 days associated with multiple episodes of vomiting with occasional fever. On Per abdomen examination was suggested distended with localised guarding at left lumbar region. Patient then posted for Emergency Exploratory laprotomy. There was intussusception with telescoping of the bowel was found. So approximately 5-7 cm of part of descending colon was resection and end to end anastomosis done. **Conclusion:** Since the majority of colonic lesions are malignant, surgical resection without reduction is typically the treatment for intussusceptions in adults. Computed tomography scanning with intravenous contrast is perhaps the most accurate method for diagnosis. For assessing intussusception, a colonoscopy may be helpful, especially if there are signs of significant intestinal obstruction.

KEYWORDS

Intussusception, Colo-colic, Obstructions, Lipoma, Masses, Substenosis.

INTRODUCTION

The first examples of intussusception were documented by Paul Barbette in 1674^[1].

Just 5% of bowel blockages in adults are caused by intussusception, a rare illness having an identified cause in 90% of symptomatic cases and an idiopathic origin in 10% of cases^[2].

According to Manouras, it occurs at a rate of 2-3 instances per 1,000,000 people year, making it extremely uncommon in the literature^[3]. Benign or malignant neoplasms account for two-thirds of lead point cases; infections, surgical adhesions, inflammatory diseases, and autoimmune disorders account for the other occurrences.

Colo-colic intussusception accounts for only 20% to 25% of all intussusceptions, making it less common than small bowel intussusception in the majority of documented case series. According to studies, because malignancies are more common in the colon than in the small intestine, colo-colic intussusception is more likely to have a malignant lead point. Adult ileocolic intussusception is a rare variation, with a malignant lead point present in almost all instances^[2].

Adenocarcinoma is the most frequent malignant cause (accounting for 66% of colo-colic intussusception cases), with 50% of cases caused by neoplasms being malignant, according to several studies. As demonstrated in our case, colonic lipoma is the most frequent source of benign masses^[4,5].

Case History

A 55 year old hindu married female patient home maker residing at surat coming from lower socioeconomic class presented in emergency at New Civil Hospital, Surat with complaining of Abdominal pain with fullness for 7 days with not passing of stool for 5 days associated with multiple episodes of vomiting with occasional fever. Patient was non diabetic non hypertensive no past history of tuberculosis or any surgery or blood transfusion. Family history was insignificant. Patient attained menopause 8 years back. She is having 2 son and daughter all are alive. Patient was moderately build with pallor was there. No any lymphadenopathy was there.

On examination patient had tachycardia 120/min with BP 100/60 mmhg With normal oxygen saturation with 18/min RR. Per abdomen examination was distended with localised guarding at left lumbar region was found. Per rectal examination was suggestive of roomy anal cavity with no stool in rectum was there. Clinical Diagnosis of

bowel obstruction made. After stabilizing patient hemodynamically with antibiotics and analgesics and iv fluids, few routine blood and radiological investigations were done and diagnosis confirmed with large bowel obstruction. Patient then posted for Emergency Exploratory laparotomy.

Intra operatively, after opening abdomen with midline laparotomy incision, peritoneal cavity opened, no contamination was there, minimal ascites found. Bowels traced. Small bowel from DJ flexure to ic junction found dilated. Cecum, ascending and transverse colon was loaded with fecal matter. At approximately 8-10 cm from splenic flexure in descending colon there was abrupt cut off with distal collapsed bowel found. There was intussusception with telescoping of the bowel (bowel within bowel found). Intussusception reduced but that part was found dusky. So approximately 5-7 cm of part of descending colon was resection and end to end anastomosis with vicryl 2-0 in connells method done. Abdominal drain kept and closure done.

That resected part of the bowel was examined which was having intra mural lipoma in mesenteric border of descending colon acting as a leading point of colo-colic intussusception. Patient was vitally stable post operatively. Patient passed stool on 4th postoperative day. Allowed to take oral diet on 5th day. No leakage observed. Drain was removed on 6th day. Patient was discharged with full Skin suture removal on 10th day post operatively without any complications.

DISCUSSION

The invagination of one bowel segment into a directly adjacent section is known as intussusception. It is the most frequent abdominal emergency that affects kids. Adult intussusception is an uncommon occurrence in emergency situations. The two most prevalent kinds are ileocolic intussusception, which affects the cecum (the first section of the colon) and the ileum (the last segment of the small intestine). Twenty to thirty percent of cases are of enteric intussusception, which involves the small intestine. Colocolic intussusception, which affects the colon, accounts for 5–10% of cases.^[6]

A lead point causes a focused area of traction that pulls the proximal bowel into the distal colon by peristaltic contractions, causing intussusception. The intussuscepted segment continues to contract peristaltically against the blockage, causing symptoms. The bowel's vascular flow eventually deteriorates, causing ischemia in the afflicted segment and subsequent consequences include necrosis and perforation. It is quite uncommon to get the traditional clinical triad of abdominal pain, palpable abdominal mass, and bloody stool. In the

age of abdominal CT scans, there is a growing recognition of instances of temporary, asymptomatic intussusception^[7].

The patient may have symptoms of intestinal ischemia or peritonitis if the presentation occurs late in the course of the illness. Laboratory results usually show nonspecific inflammatory markers including thrombocytosis and increased PCR along with an elevated white blood cell count.

With a reported prevalence of 0.2%–4.4%^[8], intestinal lipomas are an uncommon cause of adult intussusception, with just a few number of instances reported globally.

The transverse colon is one of the least common sites of onset, and Xangliang et al.^[9] provided a helpful case for comparison. Lipomas are adipocyte-derived benign tumors that are not epithelial in origin. The occurrence in the population may be higher than documented in the literature because they are frequently accidental and unrelated to symptoms. In rare instances, they may be asymptomatic even with a diameter of less than 4 cm, however they typically become symptomatic if they are larger than 2 cm^[10].

However, compared to children, adults typically have lower ultrasound accuracy. Other limitations include the presence of huge air in cases of morbid obesity or intestinal distension. However, in both adult and pediatric settings, ultrasound is frequently the first option for imaging intussusceptions. One benefit of ultrasound is that it offers quick, low-cost imaging with real-time analysis. However, intestinal distention may lessen the effectiveness of ultrasound imaging, which is dependent on operator skill^[9].

According to Wilson et al.^[11], abdominal CT is the gold standard for diagnosing intussusception, with an accuracy of 83%. The anatomical arrangement of the core intussusceptum and the outside intussusciens creates a bowel-within-bowel look, which is why classic CT findings include "target," "bull's-eye," or sausage-shaped lesions with a hyperdense double ring.

Conclusion

For assessing intussusception, a colonoscopy may be helpful, especially if there are signs of significant intestinal obstruction. However, the preferred treatment for colonic obstructive lesions is surgery, which is typically performed in an emergency. When obstructive signs and symptoms are a concern or when determining the lesion's location as part of a preoperative workup with the goal of surgical intervention, as in the case above, a colonoscopy should be performed. When it comes to diagnosing adult colocolic infections, CT scans are extremely useful. Using colonoscopy to further evaluate obstructive bowel lesions and determine whether any synchronous lesions are malignant or not has additional benefits.

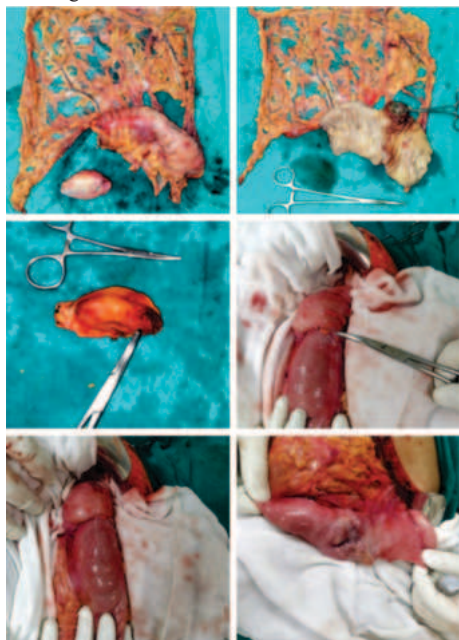


Figure 1. Intraoperative Findings



Figure 2. Xray Abdomen Findings

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