

CLINICAL IMAGE

HIV-associated intussusception

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Abstract

A 39-year-old man with untreated HIV presented with watery, non-bloody diarrhea and associated 25-lb weight loss. His workup was notable for a CT abdomen/pelvis which showed an entero-enteric intussusception of 3.4 cm without an underlying pathologic mass. The patient's intussusception resolved without intervention, as is typical of telescoping <3.5 cm. HIV is associated with an increased risk of developing intussusception because of an increased incidence of infectious and neoplastic conditions of the bowel.

A 39-year-old man with untreated human immunodeficiency virus (HIV) presented with a 2-month history of watery, non-bloody diarrhea and associated unintentional 25 pound weight loss. He had no recent sick contacts, dietary changes or travel outside the USA. He had no nausea, vomiting, abdominal pain, melena or hematochezia. On exam, his abdomen was soft and non-tender. Laboratory studies were notable for a white blood cell count of 4.13 K/μl, a CD4 count of 35 and an HIV-1 viral load of 265 000 copies/ml. An abdominal X-ray was consistent with a partial small bowel obstruction. A computed tomographic scan showed a 'sausage-like' lesion (Fig. 1a) and 'target' sign (Fig. 1b) consistent with entero-enteric intussusception of 3.4 cm without pathologic mass. Stool studies returned positive for *Cryptosporidium parvum*. As he had no symptoms suggestive of bowel obstruction or bowel ischemia, surgery was not indicated; he was admitted to our hospital for observation and supportive management. He remained asymptomatic over the next 72 h with spontaneous resolution of imaging findings, consistent with a diagnosis of transient intussusception [1]. He showed significant symptom improvement after being started on antiretroviral therapy and loperamide and was discharged home. At a follow-up appointment 2 weeks post-discharge, he reported less frequent diarrhea and still had no abdominal pain or blood in his stools.

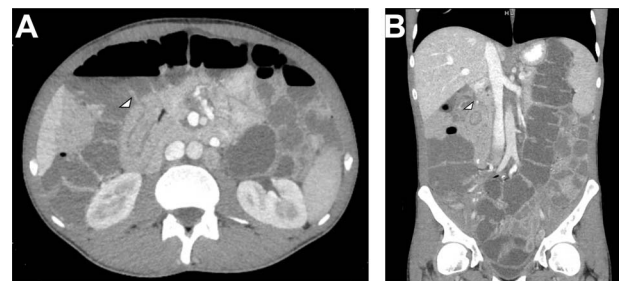


Figure 1: (a) Axial CT scan showing 'sausage-like' lesion; (b) coronal CT scan showing 'target' sign.

Intussusception is uncommon in adults, representing only 5% of all cases of intussusception and only 1% of all bowel obstructions [2]. In adults, a mechanical lead point is present in 90% of cases, which is malignant in roughly half of all cases [3]. This mechanical lead point is pulled forward by normal peristalsis, causing the small bowel to telescope into another segment of bowel. An increased risk of intussusception has been reported among patients with acquired immune deficiency syndrome (AIDS), although the true incidence is unknown [4]. This increased susceptibility to intussusception is due to a high

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incidence of infectious and neoplastic conditions of the bowel that increase the risk of developing a pathologic lead point. In particular, mesenteric lymphadenopathy is common among patients with AIDS from conditions such as lymphoma, tuberculosis, other mycobacterial infections and Kaposi's sarcoma. In addition, patients with AIDS are susceptible to intestinal infections that cause small bowel inflammation and associated lymphoid hyperplasia within the small bowel wall that may also serve as a lead point [5]. Intussusception associated with obstructive symptoms or bowel ischemia typically requires surgical intervention in adults; however, in shorter segment telescoping (<3.5 cm), there is a high likelihood of spontaneous resolution as was observed in our patient [6].

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None.

CONFLICT OF INTEREST

None declared.

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None declared.

ETHICAL APPROVAL

Not applicable.

CONSENT

Informed consent was obtained from the patient.

GUARANTOR

C.M.

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