Re: JSLS(2008)12:332-334 Laparoscopic Management of Small Bowel Intussusception in a 16-Year-Old With Peutz-Jeghers Syndrome

We read with great interest the article recently published by Gonzales AM and Clapp B in your journal [JSLS(2008)12:332-334]. They present the successful laparoscopic treatment of a small bowel intussusception in a 16-year-old male. According to the medical literature, scientific evidence is poor regarding bowel intussusception in school-age children, and it is difficult to obtain an early diagnosis. As reported, with respect to infants, in school-age children intussusception is more often a leading point, has a lower incidence of vomiting and bloody stools, more nonspecific signs or symptoms, and a lower frequency of intestinal necrosis and consequent enterectomy.[1] In particular, in the case presented by the authors, the patient was affected by Peutz-Jeghers syndrome, and the lead point was a large intestinal polyp.

The unusual and unclear presentation and the eventual absence of surgeons and radiologists skilled in pediatrics, especially in peripheral Centers, could explain the misdiagnosis and the delay in the treatment; however, the correct diagnosis remains a challenge also for specialists and particularly in teenagers.

We recently admitted to our Division of Pediatric Surgery a 15-year-old male for abdominal pain and fever, without signs of bowel obstruction. The laboratory findings showed leucocytosis (18.6x103) with neutrophilia (87.9%). The abdominal x-ray was negative, while the US scan demonstrated a lower right abdominal mass, suggestive of an appendicular abscess. To freeze the abscess, antibiotic therapy was started, and the intervention was delayed for 3 weeks. However, after 2 days, the sudden occurrence of the classic triad (biliary vomiting, bloody stools, and increasing abdominal tenderness) pushed us to reconsider the diagnosis, suspecting the intussusception. The CT scan revealed a bowel intussusception, and the repeated US scan showed the presence of the classic "target sign." Due to the clinical status of the boy, we decided on surgery.

Intraoperatively, a 30-cm tract of ischemic ileus appeared intussuscepted, with a Meckel's diverticulum as the lead point. The affected tract was resected without attempts at reduction.

This brief case is emblematic of the practical difficulties in the differential diagnosis of intussusception in teenagers not presenting with the common symptoms of intussusception. The absence of sufficient literature on this condition in teens could explain the delayed diagnosis and treatment. However, we maintain that a pediatric surgeon, particularly one without adequate radiological support, should always consider this condition when approaching a patient with abdominal pain. Only careful clinical observation and repeated radiological examinations (US, x-ray, enema, and eventually CT scan) can reduce the risk of misdiagnosis.[2]

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1. Navarro OM, Daneman A, Chae A. Intussusception: the use of delayed, repeated reduction attempts and the management of intussusceptions due to pathologic lead points in pediatric patients. *AJR Am J Roentgenol.* 2004;182:1169-1176.

2. Elsayes KM, Menias CO, Harvin HJ, Francis IR. Imaging manifestation of Meckel's diverticulum. *AJR Am J Roentgenol.* 2007;189:81-88.

Re: JSLS(2008)12:113-116 Postoperative Pain After Laparoscopic Ventral Hernia Repair: a Prospective Comparison of Sutures Versus Tacks

The article "Postoperative Pain After Laparoscopic Ventral Hernia Repair: a Prospective Comparison of Sutures Versus Tacks" by Nguyen et al found my interest.

The authors of the study are to be congratulated for tackling such a complex topic as postoperative pain in laparoscopic hernia repair. They investigate specifically the tech-