LETTER TO EDITOR

Ileoileal intussusception caused by the metastasis of cutaneous malignant melanoma to the small bowel 6 years after its excision presenting with small bowel obstruction

Sir,

I have read the paper on adult intussusception by Udo *et al*. with interest, for what I would like to thank the authors.[1] I would like to share an extremely rare and interesting case from our practice.

A 73-year-old male patient was admitted to Vladimir City Clinical Hospital of Emergency Medicine with 4-day history of colicky abdominal pain, bloating, nausea and vomiting, and absence of stools. His medical history was significant for melanoma of upper back which was excised 6 years before admission. During the follow-up, during these 6 years, he had no signs and symptoms of local recurrence or distant metastases. On admission, he was hemodynamically stable; abdominal pain and tenderness in lower abdominal quadrants and succussion splash on auscultation were revealed. Laboratory findings revealed hemoconcentration and hypokalemia. Erect abdominal X-ray revealed small bowel air-fluid levels. The patient underwent surgery after fluid and electrolyte replacement therapy. On laparotomy, multiple intestinal metastases were found. One of the metastases had an inverted shape (70 cm proximal to ileo-cecal junction) and led to isoperistaltic ileoileal intussusception [Figure 1]. Desinvagination with ileotransversal anastomosis was performed. The postoperative course was uneventful. The patient was discharged on 7th postoperative day. On the follow-up after 2 months, the patient did not have any recurrence of intussusception and/or bowel obstruction; however, metastatic disease was progressing.

Intussusception is rare in adults accounting for 3%–5% of all cases.[1] Seventy-one percent of all causes of adult enteric intussusceptions are benign neoplasms, 27% of which are owing to lipomas.[2] Malignant tumors are only detected in 20% of enteric intussusception cases, of which 50% are primary and 50% are metastatic.[2,3] Malignant melanoma ranks fifth among metastatic intestinal tumors (7%) and is considered to be the extraintestinal malignancy with the greatest predilection to metastasize to the bowel.[2] The time from index surgery, that is, the excision of cutaneous malignant melanoma, to the presentation of symptomatic enteric metastases has been reported to vary from 2 months to 15 years.[4] Clinical presentation is varicolored depending on the site and complications of intussusception. Abdominal ultrasonography is considered to be a useful tool which can reveal the intussuscept as a "target" or "pseudo-kidney" sign.[2-4] Abdominal computed tomography and capsule endoscopy have also been shown to be beneficial test in revealing intestinal melanoma. Such as in our case, in emergency cases where acute intussusception presents with intestinal obstruction with hydroionic imbalance, the diagnosis is established intraoperatively. The treatment of complicated intestinal metastatic melanoma is palliative and appears to be small bowel resection with anastomosis to relieve obstruction and control blood loss.[5] Adjuvant palliative chemotherapy can be administered postoperatively; however, evidence of its effectiveness is currently lacking.[4]

To conclude, surgeons, emergency physicians, gastroenterologists should be aware of this rare clinical entity. Patients after excision of the primary melanoma should be followed for possible emerging gastrointestinal symptoms. In patients with small bowel obstruction and a history of cutaneous malignant melanoma intussusception of enteric metastasis should be considered.

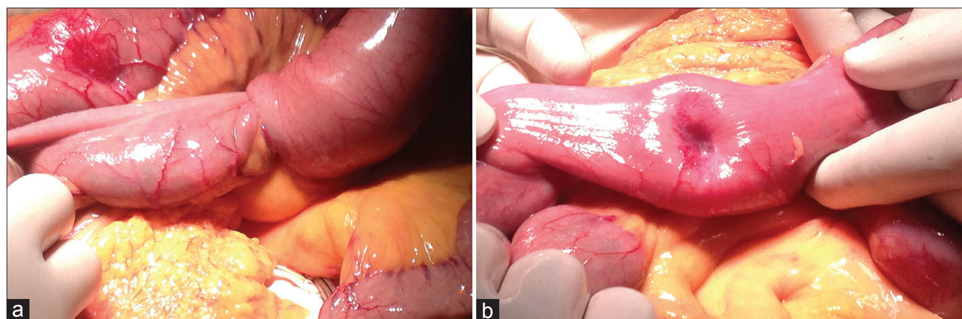

Figure 1: (a) Ileoileal intussusception intraoperatively. (b) Intestinal melanoma metastasis with an inverted shape 70 cm proximal to the ileocecal junction

© 2017 Nigerian Medical Journal | Published by Wolters Kluwer - Medknow

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Gachabayov Mahir

Department of Abdominal Surgery, Vladimir City Clinical Hospital of Emergency Medicine, Vladimir, Russia

Address for correspondence:
Dr. Gachabayov Mahir,
Stavrovskaya Street, 6-73, Vladimir 600022, Russia.
E-mail: gachabayovmahir@gmail.com

REFERENCES

1. Udo IA, Abudu EK, Uduma F. Adult intussusception: An 8 years institutional review. Niger Med J 2016;57:204-7.
2. Kouladouros K, Gärtner D, Münch S, Paul M, Schön MR. Recurrent intussusception as initial manifestation of primary intestinal melanoma: Case report and literature review. World J Gastroenterol 2015;21:3114-20.
3. Chiang JM, Lin YS. Tumor spectrum of adult intussusception. J Surg Oncol 2008;98:444-7.
4. Vigorita V, Ausania F, Bertucci Zoccali M, Alvarez CF, Nadal Bde U, Nuñez JE. Small bowel intussusception secondary to metastatic melanoma 15 years after complete excision of the primary tumor. Int J Surg Case Rep 2015;6C:26-8.
5. Malik P, Mandia R, Maheshwari R, Sharma DC. Jejuno-jejunal intussusception: An unusual presentation of malignant melanoma. Australas Med J 2014;7:416-8.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Access this article online	
Quick Response Code:	Website: www.nigeriamedj.com
	DOI: 10.4103/0300-1652.219347

How to cite this article: Mahir G. Ileoileal intussusception caused by the metastasis of cutaneous malignant melanoma to the small bowel 6 years after its excision presenting with small bowel obstruction. Niger Med J 2017;58:84-5.