CASE REPORT

Adult Intussusception

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A B S T R A C T

Adult intussusception is rare. We report the case of an elderly female patient with an ileocecal intussusception who underwent resection and ileocolic anastomosis. The histology revealed chronic inflammation of the ileum and cecum and there was no evidence of malignancy. There was no evidence of malignancy. The appendix showed fibrous obliteration of the lumen.

Key words: Elderly, intestinal obstruction, intussusception

ملخص البحث:
الانغلاف أو الانغماد المعوي يعتبر من أكثر الأسباب شيوعا التي تسبب الانسداد المعوي لدى الأطفال ولكن من النادر أن يحدث ذلك لدى الكبار وعادة ما تكون الأعراض والعلامات غير واضحة ومبهمة. يكمن علاج الانغلاف المعوي لدى الكبار جراحيا وذلك لان مسبباته غالبا ما تكون مرضية أو سرطانية. يصف الباحثون في هذا التقرير حالة مريضة عمرها 74 سنة تعاني من الانغلاف المعوي ما بين المعي الاعور واللفافي كما يناقشون طرق التشخيص وعلاج مثل هذه الحالات.

INTRODUCTION

Intussusception is a rare cause of intestinal obstruction in adults. The diagnosis of intussusception is usually delayed because of its nonspecific presentation.[1] Nevertheless, intussusception is an important differential diagnosis because it is mainly due to a pathological mass lesion.[2] Surgical treatment is the main choice of the treatment compared to the pediatric population, where clear signs and symptoms are presented and therefore, the condition can be mainly managed by nonoperative procedures.[3]

CASE REPORT

A 74-year-old female was admitted to King Faisal Hospital in Makkah as a result of severe abdominal pain and vomiting of for 3 days and constipation of 1-day duration. The pain had started gradually in the right hypochondrium, which was localized, colicky in nature and progressive with no aggravating or relieving factors. The patient was able to pass flatus, apyrexial and had no urinary symptoms. Nothing of significance in the patient's history was reported, apart from hypertension.

Upon physical examination, the patient looked dehydrated, blood pressure was 105/70, other vital signs were in the normal range. She had slight abdominal distention with diffuse abdominal tenderness, no audible bowel sounds. The rectal examination revealed an empty rectum with no evidence of melena or fresh blood. The rest of the physical examination was unremarkable.

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The patient's laboratory results showed leukocytosis (14.6×10^9/L), other laboratory work was normal including hemoglobin and chemistry. Arterial blood gas analysis was normal and her chest x-ray was unremarkable. Abdominal plain film showed typical picture of a small bowel obstruction: Distended small bowel loops in the supine position and air fluid level in the mid-abdomen in the erect position.

A clinical diagnosis of small bowel obstruction was made and the patient was started on conservative treatment (nasogastric tube suction, intravenous fluid rehydration and monitoring). Symptoms and signs improved, but on the 3rd day post-admission, she started passing red-brownish jelly and smelly stools. A CT of the abdomen was done, which showed an appendicular mass and accumulation of fluid in the pelvis without signs of obstruction. On the 4th day of admission, the patient relapsed and reported that her pain had increased. A decision was made to proceed with an emergency laparotomy. Through a midline incision, an ileocecal intussusception was found with viable bowel and a cecal mass as the lead point [Figure 1]. Three liters of fluid had accumulated in the pelvis. Resection and end-to-end ileocolic anastomosis were undertaken. The patient made an uneventful recovery. The histology revealed chronic inflammation of the ileum and cecum with no evidence of malignancy. The appendix showed fibrous obliteration of the lumen.

DISCUSSION

Intussusception is defined as telescoping of part of the intestine into another part causing obstruction, inflammation and ischemia which may lead to necrosis.[1] It is a major and common cause of abdominal pain and obstruction in the pediatric population. However, in the adult population, it only represents 1–5% of all causes of obstruction.[4] The most common place for an intussusception to occur is between a freely moving segment and an adhesionally fixed segment. There are different types of intussusception depending on the anatomic site. For example, enteroenteric occurs in the small bowel, colocolic occurs only in the large bowel, ileocolic occurs in the terminal ileum and ascending colon and finally, ileocecal which occurs in the ileum and cecal valve.[2,5,6] The etiology of intussusception in children is mainly idiopathic, but in adults just 8–20% of cases are considered as a primary or idiopathic; secondary intussusception is believed to occur because of pathological lesions that serve as a lead point such as carcinomas, polyps, Meckel's diverticulum and strictures.[2-4] The diagnosis of intussusception in adults is quite challenging with only 40–50% diagnosed preoperatively.[7,8] The x-ray findings are limited to air fluid level and dilated loops.[8] Ultrasound is considered a useful tool in adults and children.[8,9] A CT scan is considered to be the best for diagnosis in the majority of cases (58–100%).[1,4] Most intussusceptions that occur in adults require operative intervention (resection and anastomosis) because of the high incidence of pathological lesions and malignancy.[1]

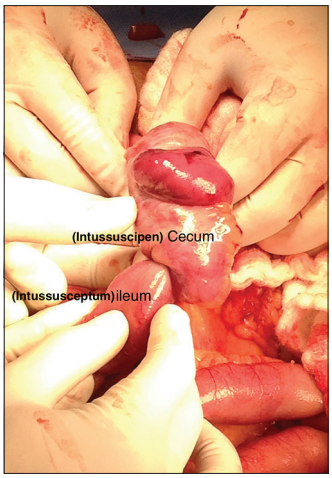

Figure 1: Gross pathology of ileocecal intussusception

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Conflicts of interest

There are no conflicts of interest.

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