Case Report **DOI: 10.56412/gmcp.2024.7.01.173**

INTUSSUSCEPTION IN ADULTS: A RARE PRESENTATION

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Abstract

Intussusception is more commonly seen children and is a rare cause of intestinal obstruction in adult population. In adults, intussusception occur following a lead point. Here is a case report of 24 years old male presented with complaints of pain in the right iliac fossa, vomiting and obstipation. On examination irregular mass was palpated in the right lumbar region. Laboratory were within normal range and radiological investigations were done which showed ileocecal intussusception with ileocecal mesenteric lymph nodes. Colonoscopy showed large polypoid lesion involving IC junction causing ileocolic intussusception. Patient underwent Exploratory laparotomy and ileocecal resection with end to end ileo ascending colon anastomosis done. The presentation, diagnosis and treatment of intussusception varies between paediatric and adult age group.

Introduction

Intussusception is a potentially fatal condition that happens when a section of the intestine bends like a telescope, with one segment slipping inside another. The proximal portion that telescopes into the intestine is known as the intussceptum, and the distal portion that receives the proximal portion is known as the intussuscipiens. This process can lead to multiple complications such as bowel obstruction, bowel necrosis/gangrene leading to sepsis. The disease process is much more common in the paediatric population and uncommon in adults, but when present is likely to be due to a pathological lead point such as benign or malignant masses [1].

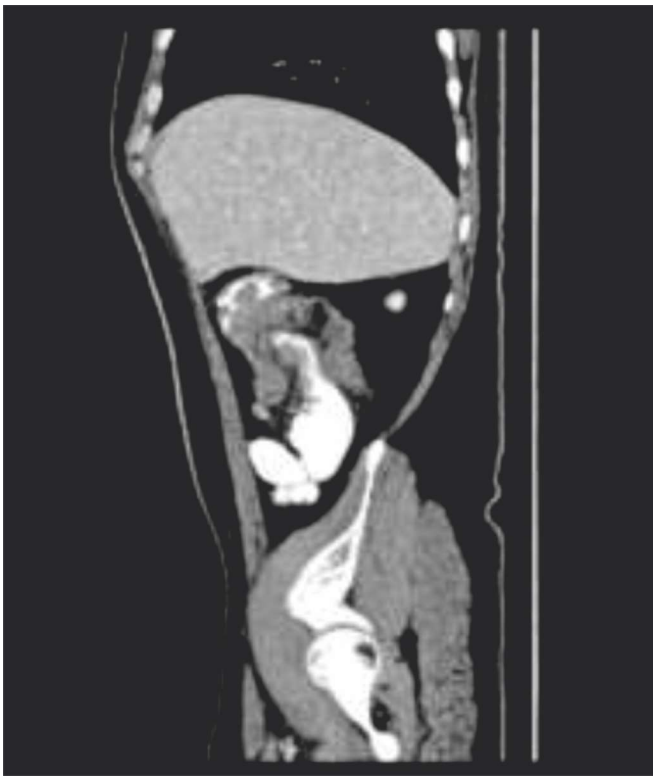
Case summary

24 years old male presented with complaints of pain in the right iliac fossa radiating to paraumbilical area for 4 months, was acute in onset and colicky in nature, on and off pain and bleeding per rectum which was dark red in colour for 4 months and 1-2 episodes of non-bilious vomiting on and off with inability to pass flatus and faeces for last 2 days. Previous history of altered bowel habits, loss of appetite and loss of weight were present. There was no history of red currant jelly stools. General physical examination of the patient was normal. Patient had average built with no pallor. On inspection, there was no visible swelling and no distention. On palpation, A palpable abdominal mass was felt in the right lumbar region extending upto the right hypochondrium and the epigastric region which was irregular in shape. Margins were not well defined with size of around 7-8 cm, Soft in consistency, there was no movement with respiration and all the quadrants were moving equally with respiration. Generalized tenderness present. Auscultation revealed increasing bowel sound. Per rectal examination indicated presence of stools without any blood staining.

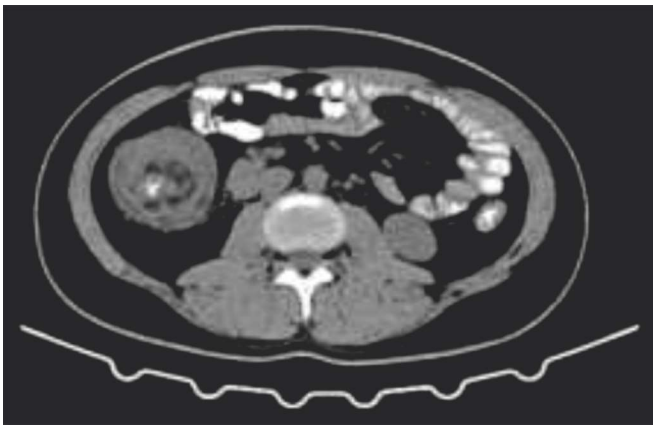
Investigations

Laboratory investigation revealed Haemoglobin to be 11 gm/dL. TLC/LFT/RFT were within normal limits. On Radiological investigation, CECT ABDOMEN showed telescoping of ileocecal junction into the caecum and proximal ascending colon with involvement of base of appendix S/O ileocecal intussusception with diffuse circumferential wall thickening about 20mm multiple enlarged homogeneously enhancing lymph nodes are noted in the right ileocecal mesentery with largest of the lymph node measures 18 mm in short axis diameter [Figure 1]. Colonoscopy showed large polypoid lesion involving IC junction causing ileocolic intussusception. Histopathology from the caecal polypoidal lesion showed ulcerated mucosa with submucosa infiltrated with marked lymphoplasmacytic infiltrate [Figure 2].





B. Sagittal Section



C. Axial Section

Fig. 1 A, B, C showing telescoping of one of the ileal segment into colonic loop

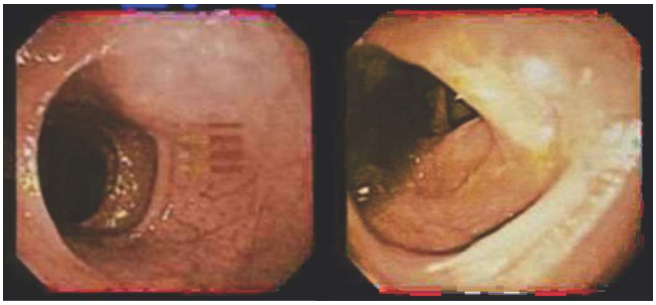


Fig. 2 Histopathology from the caecal polypoidal lesion showed ulcerated mucosa

Surgical Procedure

Exploratory laparotomy was performed, and manual reduction of the intussusception was tried but was unsuccessful and then resection of the involved bowel segment was planned, and ileocecal resection was done and end to end ileoascending colon anastomosis was done [Figure 3].



Fig. 3 Thickened, congested and inflamed terminal ileum with ileo-colonic intussusception

Discussion

Intussusception is uncommon in adults than paediatric age group. About 2-3 cases per million people are reported annually. Adults with intussusception have a different aetiology, presentation, and process of management than children. Most often, intussusception in children is idiopathic or a consequence of a viral infection. However, in over 90% of adult instances, a lead point that causes the intussusception can be identified. [2]. These lead points can be malignant neoplasms like adenocarcinoma, benign tumour adenomatous polyps, lymphoid hyperplasia, lipoma, cystic fibrosis, celiac disease, inflammatory bowel disease, appendicitis, pancreatitis, and rectal foreign bodies [3]. Adults with this condition have a relatively non-specific clinical appearance, which makes diagnosis challenging. Common symptoms include nausea, diarrhoea, bleeding per rectum, and pain in the abdomen. Rarely, acute bowel obstruction could appear. Seldom does an adult exhibit the characteristic trifecta of red currant jelly stools passing, a sausage-shaped palpable mass, and abdominal discomfort that children encounter. [2]. In contrast to the paediatric age group, the management of adult intussusception differs. Resection of the involved bowel and anastomosis remains the treatment option for adults.

Conclusion

Adult intussusception is an uncommon but challenging condition for the surgeon to manage. Due to inconsistent symptoms and a lack of the pathognomonic clinical picture associated with intussusception in children, preoperative diagnosis is frequently overlooked or delayed. In the present case, the patient's symptoms were nonspecific. When diagnosing intussusception, abdominal CT scans are thought to be the most reliable imaging technique available. Surgical intervention is required because adult intussusception is usually linked to

malignant organic lesions. Anastomosis and formal excision of the affected intestinal segment are typically required as part of the surgical procedure. When a small intestinal intussusception is viable or there is no suspicion of malignancy, manual reduction may be performed.

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