Case Report

ILEOCOLIC INTUSSUSCEPTION: A RARE CASE OF ACUTE INTESTINAL OBSTRUCTION IN ADULTS

Nayab Alia[1], Fareha Amin[2], Faryal Saeed[3]
[1]*Assisstant Professor, University Medical and Dental College, Faisalabad.*
[2]*Medical officer, Madina Teaching Hospital, Faisalabad.*
[3]*House Officer, Madina Teaching Hospital, Faisalabad.*

ABSTRACT

Intussusception is a rare cause of acute intestinal obstruction in adults. The etiology, clinical presentation and management of condition is different in adults as compared to pediatrics age group. Pre-operative diagnosis is usually difficult due to non-specific and intermittent nature of symptoms. Ultrasound can be helpful in diagnosing the condition. Target sign or Doughnut sign and sandwitch appearance/pseudo kidney sign are helmark of diagnosis.

CASE REPORT

A 62 years old male presented with a two month history of intermittent abdominal pain and constipation. On examination he was pyrexic and heamodynamically stable. His abdomen was distended with localized tenderness in right iliac fossa and no palpable abdominal mass. Ultrasonography showed classical "target sign" or "Doughnut sign" {Figure 1). The longitudinal appearance of intussusception usually appears as multiple parallel lines called "pseudo kidney sign" (Figure 2). There were multiple echogenic small lesion in gut wall average size is 5x7mm (Figure 2). Multiple fluid filled dilated loops seen all over the upper abdomen. Our sonographic impression was intestinal obstruction due to ileocolic intussusception, and leading point was lipoma/polyps. The leading point was polyps confirmed upon exploratory laparotomy with subsequent right hemicolectomy.

DISCUSSION

Intussusception, defined as invagination of a proximal part of bowel along with its mesentery into an adjacent segment, leading to impaired peristalsis, obstruction and possible vascular compromise[1]. The classic triad of intermittent abdominal pain, bloody diarrhea and palpable tender mass has been described primarily in children.[2] However in adults nausea, vomiting, changes in bowel habits and abdominal distention are the more common non-specific symptoms and signs of intussusception.

In the adult population intussusception is a rare condition accounting for only 5% of reported cases and 1-5% of small bowel obstructions.[3] It is usually secondary to an identifiable bowel lesion in 90% cases. This lead point could be intraluminal lesions such as inflammatory lesion, polyps, Meckels diverticulum or extra luminal lesions such as adhesion lipoma, lymphomas and metastases.[4] Malignancy are associated with 30% of small bowels intussusception and 66% of large bowel intssusception.[5]

Intussusception are classified according to their location; enteroenteric, colocolic. ileocolic and ileocecal.[5] As in our case the presenting symptoms and signs were not specific for intussusception abdominal pain and distention along with changes in bowel movements are symptoms associated with a long list differential diagnosis.

Radiological imaging help in narrowing down and focusing attention to a sub set of possible etiologies. Plain abdominal radiograph is

Corresponding Author:
Dr. Nayab Alia, Assistant Professor,
University Medical & Dental College, Faisalabad.
Email: benz.baluch@hotmail.com

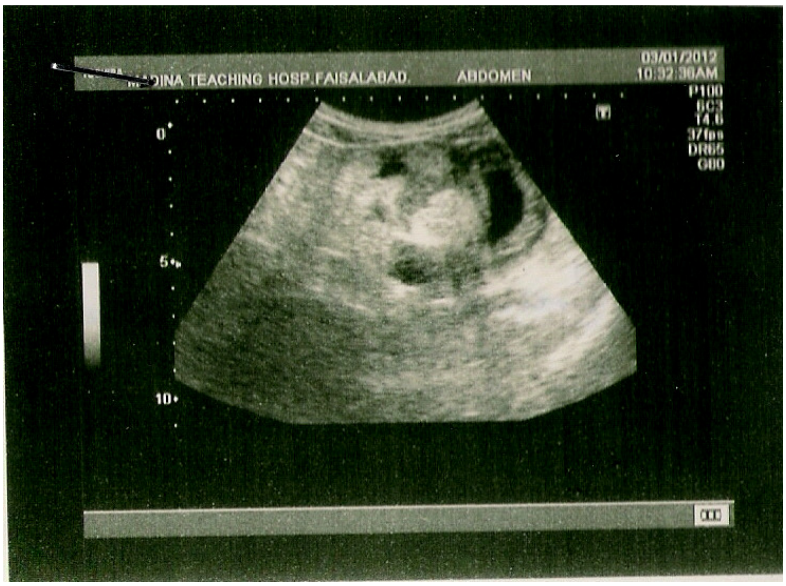

Figure 1. Transverse view show target sign.

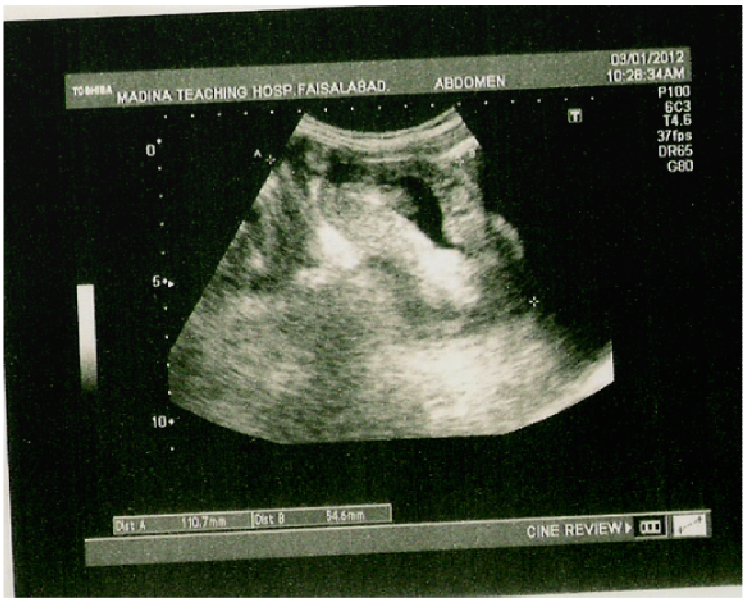

Figure 2. Longitudinal view show multiple layers of gut. Multiple lesion in gut wall could be lipoma.

typically the first diagnostic screening tool demonstrating a bowel obstruction or perforation, however radiograph are neither sensitive nor specific for intussusception.[6] Ultrasonography is a useful clinical tool for diagnosis of intussusception with high sensitivity and specificity: 98-100% and 88% respectively.[4] Ultra sonography reveals a "target" or "doughnut" sign on transverse view and "pseudo kidney" sign in the longitudinal view[7]. The major limitation of Ultrasonography for evaluating acute obstructive symptoms is the presence of air in bowel. Surgical resection of involved bowel segments serves as treatment of choice in adult population.[7]

CONCLUSION

Ultrasonography is first choice in diagnosing intussusception because of its classical appearance and high diagnostic accuracy. We

believe role of ultra sound extends beyond that it confirms the diagnosis, it can be used in several cases to identify pathological lead point.

REFERENCES

1. Marinis A, *et al.* Intssusception of bowel in adults: a review. *World J Gastroenterol.* 2009 Jan 28; 15(4): 407-11.
2. Buettcher M, Baer G, Bonheoffer J, *et al.* Three years surveillance of intussusception in children in Switzerland. *Pedatrics.* 2007; 120: 473-480.
3. Barussaud M, Regenet N, Briennon X. *et al.* Clinical spectrum and surgical approach of adult intussusception. *Int J Colorectal Diseases.* 2006; 21: 834-839.
4. Balamoun H and Doughan S. Ileal lipoma–a rare case of Ileocolic intussusception in adults. *World J Gastrointestinal Surgical,* 2011 Jan 27; 3(1): 13-5.
5. Erkan N. Haciyanh M, Yilirim M, Sayhan H, Vardar E and Polat AF. Intussusception in adults. *Int J Colorectal Dis.* 2005: 20: 425-456.
6. Howard N, Pranesh N and Carter P. Colocolonic intussusception secondary to lipoma. *Int J Surgery Case Rep.* 2012; 3(2): 52-4.
7. Khan MN, Agarwal A and Strauss P. Ileocolic intussusception. A rare cause of acute intestinal obstruction in adults; case report and literature review. *World J Emerg Surg.* 2008; 3: 26.

Submitted for publication: 10-02-2012

Accepted for publication after major revision: 26-03-2012