

INTUSSUSCEPTION IN ADULT MALE

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BACKGROUND

Intussusception is highly uncommon in adults and accounts for 5% of all reported cases, Dean DL et al^[1] and Gayer G, and Apter S^[2] compared to children, where it is more often encountered. A definite identifiable bowel lesion, e.g. polyp, tumour, diverticulum and foreign body is found in 90% of cases. In remaining 10%, the cause is idiopathic. Diagnosis is difficult because of non-specific symptoms and its rarity, Han AM et al.^[3] Diagnostic modalities include-

1. Radiography.
2. Ultrasonography.
3. Computed tomography.

We present the case of an adult male patient with no previous operations, no underlying pathology of intestine.

PRESENTATION OF CASE

We present the case of a 24 year old male patient from rural background. He presented to our emergency department complaining of peri-umbilical pain for several days.

The pain was moderate in severity and colicky in nature associated with nausea and vomiting.

There was no remarkable previous history.

CLINICAL DIAGNOSIS

Abdominal examination revealed a soft-firm mass around the umbilicus with moderate tenderness; however, no rebound tenderness or abdominal guarding was present. Bowel sounds were increased and rectal examination was normal. The patient looked pale and dehydrated with tachycardia and blood pressure towards lower side.

Biochemistry and blood counts were within normal range. Radiograph revealed ileus of small intestine without any gas under diaphragm. USG revealed only dilated bowel loops. A contrast enhanced CT confirmed the finding of small bowel intussusception.

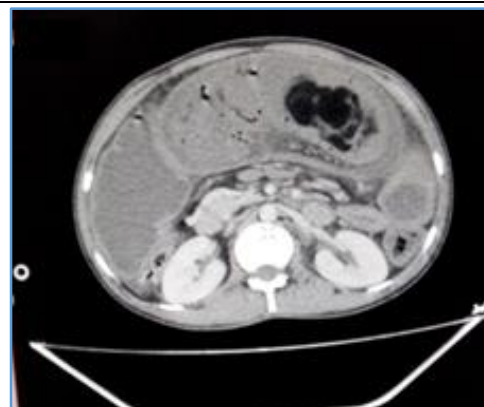


Figure 1. CT showing Small Bowel Intussusception

DIFFERENTIAL DIAGNOSIS

Intussusception is relatively rare in adult population and this along with the vague clinical feature makes diagnosis difficult, Karamercan A, Kurukahvecioglu O.^[4] Causes of intussusception can be divided into four groups, Agha F.^[5]:

1. Tumour related.
2. Post-operative.
3. Miscellaneous (Meckel's diverticulum, coeliac disease).
4. Idiopathic.

PATHOLOGICAL DIAGNOSIS

The resected portion was sent for histopathological examination, which did not reveal any remarkable cause for intussusception.

DISCUSSION OF MANAGEMENT

Exploratory laparotomy was done, which revealed a massive ileo-ileal intussusception involving more than 7 feet of bowel. Manual reduction was done and entire length of bowel including intussusception and intussuscepiens was found to be gangrenous. Merine D, Fishman EK, Jones B, Siegelman SS^[6]



Figure 2. Reduction of Intussusception

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Resection of the non-viable part of ileum was done (7FT). Since the oedema and necrotic condition plus the general condition of the patient prevented us from primary anastomosis. A proximal end ileostomy was done with closure of distal loop. Nagorney DM, et al.^[7]



Figure 3. Resected Bowel Segment (7 ft)

FINAL DIAGNOSIS

Although, the mechanism that lead to an intussusception is still unknown, any lesion or irritation of the bowel wall or lumen that de-synchronises the peristaltic waves could provide the mechanical cause for invagination of one part of intestine into another.

Since the existence of a tumour, polyp, diverticulum or adhesions due to preceding operation were excluded as far as our patient was concerned, it can be speculated that dysrhythmic peristalsis may be the cause of intussusception.

Only rarely can we detect adult intussusception in the absence of underlying pathology. Aston SJ, et al.^[8]

It still remains to be investigated to fully understand the pathomechanism of idiopathic intussusception. CT scan can be of great value in diagnosis as it reveals the site, level and cause of obstruction and also displays the signs of threatening bowel viability. Marshak RH,^[9] Merine D.^[6]

However, idiopathic intussusception should form a part of curriculum in emergency room to rule out obstruction in young adult.

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