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Case Report

A Rare Case of Adult Intussusception

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Abstract

A 33-year-old male from Bangladesh works at Saudi Arabia visited King Saud Medical City emergency room with perianal pain and protruding mass from the anus. The patient had this mass 3 days before seeking treatment. The patient has history of constipation for years. The physical abdominal examination showed a soft, lax abdomen with no tenderness and there was a mass protruding from the anus which has mixed yellowish and purple color.

Keywords: Intussusception; Bowel obstruction; Protruding mass

Introduction

The telescoping of a proximal segment of the gastrointestinal tract in the lumen of the adjacent segment known as Intussusception of the bowel. Intussusception is common in the children with common symptoms such as, palpable tender mass, abdominal pain and bloody diarrhea. However, this condition is very infrequent in adults about 5% of all patients of intussusceptions [1]. In this case report, we are presenting one of the rare causes of idiopathic colo-colonic intussupsceton.

Case Presentation

A 33-year-old male from Bangladesh works at Saudi Arabia visited King Saud Medical City emergency room with perianal pain and protruding mass from the anus. The patient had this mass prior 3 days before seeking treatment. The patient has history of constipation for years. The physical abdominal examination showed a soft lax abdomen with no tenderness , no palbaple masses and there was a non tender mass protruding from the anus which has mixed yellowish and purple color.

In the emergency room, there was an attampted to reduce the mass manually but did not succeed. However, the patient was admitted into general surgical department. The laboratory test was in the normal range. The patient was sent to the radiology department to do a Computed Tomography (CT) for more investigating. The radiology report indicates; Collapsed, intussuscepted descending colon (intussusceptum) with the mesenteric fat and vessels telescoped into the lumen of the sigmoid colon (intussuscipiens) (Figure 1).

According to the CT scan and the patient physical examination the patient was diagnoses with bowel Intussusception.

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Surgical Intervention

The patient was instructed nothing per mouth 24 hours before the surgery and normal saline intravenous fluid was given. In addition, the patient was on cefuroxime (1 gm intravenous twice a day), metronidazole (500 mg intravenous three times a day) and paracetamol. Emergancy lapratomy has been decided.

During the surgery a dilated colon proximal to sigmoid and multiple enlarged lymph nodes along the mesentery of the sigmoid and descending colon were seen. In addition, the proximal sigmoid is entering (intussuscept) into next sigmoid segment (Figure 2).

Parital resection of the sigmoid (a 15 cm segment from the sigmiod has been resected. started 5 cm proximal to invaginating part (sigmoidectomy) (Figure 2C) and side to side primary anastomosis has been done between the descending colon and distal sigmoid. Finally, mesentery defect closed. A biopsy was sent to the histopathology for more investigation. The final result of the histopathology is focal mucosal sloughing and ulceration associated with chronic inflammation with granulation tissue hemorrhage; acute and chronic serositis no sign of malignancy Lymph nodes biopsy showed no malignancy.

After the surgery also the patient was instructed nothing per month for three days and saline intravenous fluid was given after that, he was in diet fluid for two days. In addition, a paracetamol and tramadol prescripted. He was discharged two weeks after surgery and a follow-up appointment after a month. In his follow up visit full recovery was confirmed.

Discussion

An invagination of a segment of bowel into the lumen of an adjacent segment called intussusception. This invagination might cause many complications as sepsis, bowel necrosis and bowel obstruction. Intussusception is common in pediatric patients more than the adults and consider a rare (1% of adult patients with bowel obstruction) and challenging disease when adults are diagnoses with intussusception [2,3]. In addition, Intussusception in children mostly idiopathic and there is no operative reduction required for most cases is sufficient treatment. On the other hand, in adult often that will associate with pathologic history or malignant tumor. Nevertheless, a surgical decision usually recommended [3].

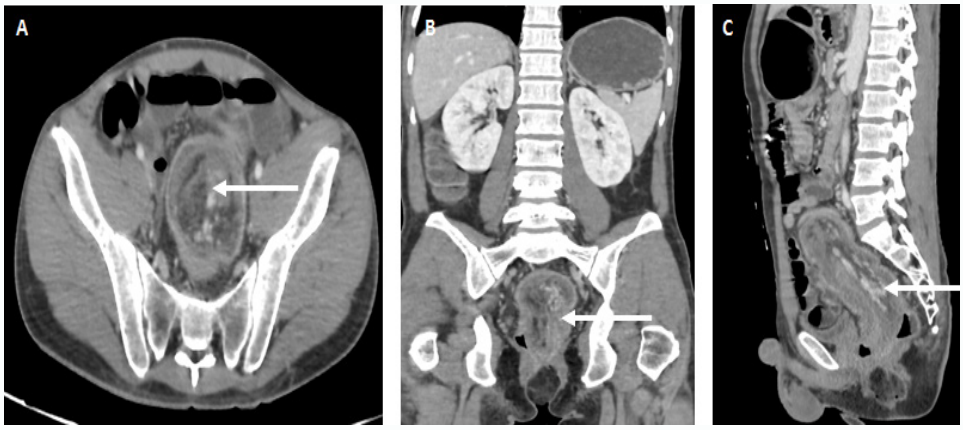

Figure 1: CT abdomen and pelvis in portovenous phase. (A) An axial view (B) Coronal view and (C) Sagittal view. Collapsed, intussuscepted descending colon (intussusceptum) with the mesenteric fat and vessels telescoped into the lumen of the sigmoid colon (intussuscipiens).

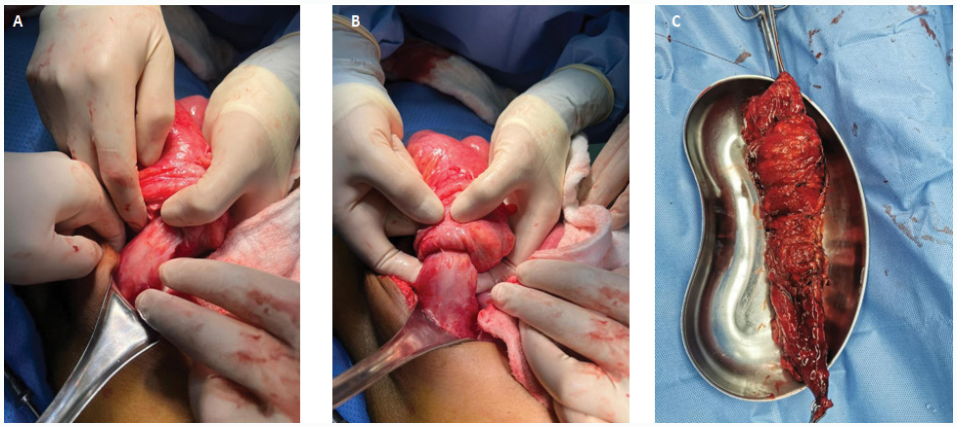

Figure 2: (A, B) Proximal sigmoid is entering (intussuscept) into next sigmoid segment. Partial sigmoidectomy a 15 cm segment from the sigmiod has been resected. Started 5 cm proximal to invaginating part (C).

CT has an advantage to diagnoses intussusception without surgical approach [4]. A retrospective study done in 2009 showed CT scan has accuracy of 90.5% when diagnoses intussusception [5]. CT usually shows a "bull's-eye" sign of intussusception obstruction [6].

Conclusion

Surgery is the centerpiece in adult intussusception. However, in this case report the patient symptoms, physical abdominal examination that showed mass and CT scan were countless help in diagnoses and treat the patient.

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