

Intussusception in Elderly: A Case Report

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Abstract: *Intussusception is a common malady of the paediatric population. However adult intussusception is a rare entity and accounts for less than 5% of all cases of intussusception⁶. This is a case study of an elderly female presenting with vague abdominal complaints whose CT revealed an ileocolic intussusception. Patient underwent emergency exploratory laparotomy and was found to have a malignant ileocecal growth. The pathological report described the growth as non – Hodgkin’s lymphoma. Unlike their paediatric counterpart, majority of the adult intussusception have a pathological lead point which requires evaluation by clinical examination and investigations. This study highlights the importance of high index of clinical suspicion and role of computed tomography in diagnosing intussusception in elderly. It also emphasizes on aggressive surgical management as opposed to conservative approach in such patients.*

Keywords: Intussusception, elderly, Non - Hodgkin’s Lymphoma, Ileo - colic intussusception, Computed tomography

1. Introduction

Intussusception is the telescoping of proximal bowel into the distal bowel or vice versa. It is a common malady of the paediatric population; however, it accounts for less than 5% of cases of small bowel obstruction in adults¹. While in children, the intussusception is usually idiopathic, about 90% of intussusception in adults is secondary to an organic cause³. Adults rarely present with the classical symptoms of colicky abdominal pain, vomiting and abdominal lump, making preoperative diagnosis often difficult. Abdominal CT is the imaging modality of choice in adults. Emergency surgical resection is preferred over conservation management in adults⁴.

2. Case Description

Present history: 65 - year - old female who presented with abdominal pain for six months with no history of vomiting or altered bowel habits.

Past history: There is history of unexplained weight loss over past 6 months. Patient had no medical comorbidities or surgical history.

Examination: Patient was haemodynamically stable and abdomen was soft with tenderness in the umbilical and right iliac region. No guarding, rigidity or distension present. Per rectal examination revealed an empty rectum.

3. Investigation

Hemogram was within normal limits.

Ultrasound of the abdomen and pelvis: There was evidence of 3.8cm × 6.5cm × 5.5cm heterogeneously hypoechoic lesion with fairly defined borders with significant internal vascularity arising from small bowel loops to the right of umbilicus. Multiple small bowel loops are clumped together adjacent to the above lesion. These bowel loops are non - dilated and show normal peristalsis. Multiple enlarged mesenteric, pre and paraaortic lymph nodes noted largest measuring 1.6 cm × 2 cm

Abdominal X - ray: Normal

Abdominal contrast computed tomography: Short segmental heterogeneously enhancing bowel wall thickening is noted involving caecum with maximum thickness measuring 1.4 cm. There is telescoping of terminal ileal loops, IC junction, caecum and ascending colon into transverse colon for a length of approximately 7 - 8 cm in epigastric region suggestive of ileo - colic intussusception. However proximal bowel loops appear non dilated. Multiple heterogeneously enhancing enlarged lymph nodes are noted in mesentery largest measuring 4cm × 3.2cm in right iliac fossa region.



Figure 1 and 2: Evidence of Ileo - colic intussusception seen

Volume 11 Issue 12, December 2022

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Figure 3: Resected segment showed proliferative growth in the distal ileum and caecum



Figure 4: Right Hemicolectomy with ileo - transverse anastomosis done

Management

Emergency exploratory laparotomy was done. Telescoping of distal ileum, caecum and ascending colon up to the splenic flexure and enlarged mesenteric lymph nodes was observed. Anulcero - proliferative growth in the distal ileum, caecum and proximal ascending colon was seen. Right hemicolectomy with ileo - transverse anastomosis was performed. The growth was sent for histopathological examination. Histopathological findings were as follows

- Tumour site: Ileocecal junction
- Histological type: NHL B Cell type
- Total Lymph nodes: 17
- 16 out of 17 lymph nodes were involved.
- Resection margin free of tumour

- IHC report - BCL2: Positive (Fig 5), CD 20: Positive (Fig 6), CD 3: Negative (Fig 7) and HMW - CK: Negative

Post operative period was uneventful with return of the bowel function on day six. Patient was eventually discharged.

4. Discussion

Intussusception is a major cause of bowel obstruction in children with peak incidence at 5 - 7 months of age⁵. While paediatric intussusception is usually idiopathic, about 90% of intussusception in adults is secondary to an organic cause. Intussusception accounts for less than 5% of all cases of small bowel obstruction in adults¹. Children present with classical symptoms of colicky abdominal pain, vomiting, mucus or blood - tinged stools and a palpable abdominal lump. Due to non - specific clinical presentation in elderly, the preoperative diagnosis is often delayed. Intermittent abdominal pain is the most common symptom in adults followed by vomiting and rectal bleeding². Abdominal computed tomography is the diagnostic imaging modality of choice in adults. Unlike the conservative approach followed in children, adults intussusception requires emergency exploratory laparotomy with primary en bloc resection. Initial reduction prior to resection is not recommended as there is high incidence of malignancy in adults with the possibility of venous embolization and intraluminal seeding⁴.

5. Conclusion

To conclude, given the rarity of adult intussusception, a low threshold for exploration and a high degree of clinical suspicion should be practised in such cases.

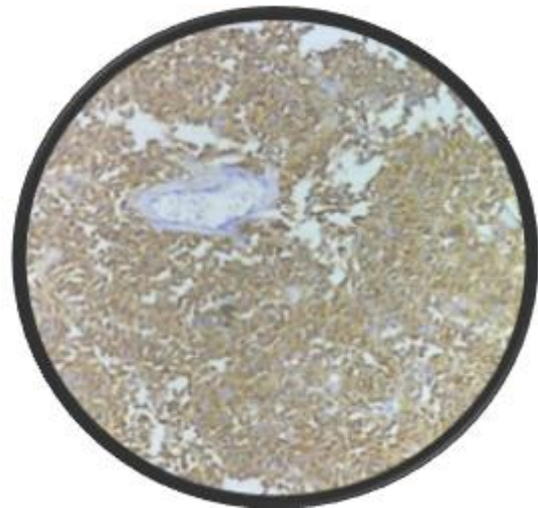


Figure 5: BCL2 Positive

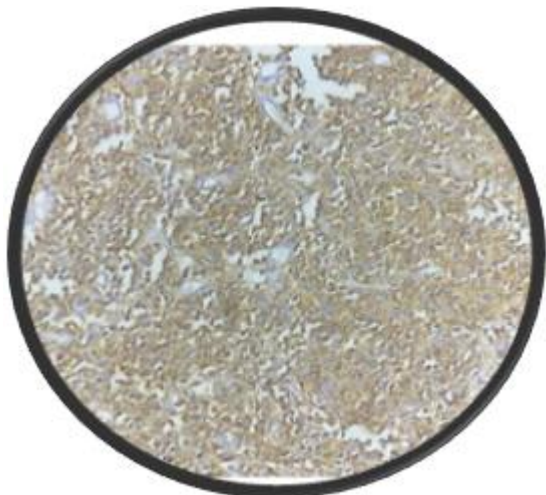


Figure 6: CD 20 Positive

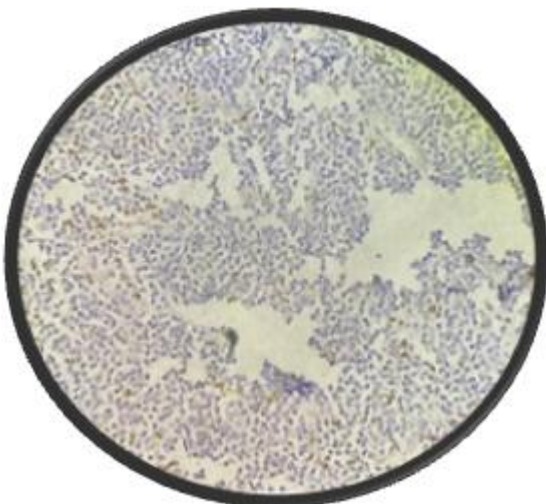


Figure 7: CD 3 Negative

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