

A Rare Presentation of Adult Retrograde Jejunojunal Intussusception: Case Report and Surgical Management

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Keywords: intussusception, adult, retrograde, jejunojunal, surgical management

1. Introduction

The intussusception is telescoping or invagination of one portion (segment) of bowel into the adjacent segment which is usually seen in the age group of 5 months to 10 months. (1, 2) In adults majority have lead point, however 20% are idiopathic, accounts for 2% of bowel obstruction. Ileoileal (77%) is the most common type followed by ileocolic (12%). (3, 4)

Presentation of the case: A 64 year old elderly patient presented to GMCH casualty.

Symptoms: Features of gastric outlet obstruction (repeated vomiting & abdominal distension with pain since 4 days and non passage of stool since 3 days). (5)

Signs: Abdomen distended with tenderness over epigastrium and absent bowel sounds. (6)

Vitals: PR-120/min, BP-98/60mmHg, RR-22/min and SPO2: 93% On RA.

2. Investigation (7, 8)

USG showed bowel within bowel appearance giving target sign possibly suggestive of intussusception. The intussusceptum measuring about 5.9cm and there is gross dilatation of stomach and small bowel loops suggestive of

subacute intestinal obstruction and in NCCT scan a well defined fat density lesion measuring 4.9cm*1.58cm*2.7 cm is seen in small bowel. There is herniation of small bowel loop into proximal bowel (retrograde intussusception) with the length of intussusceptum measuring about 9.5cm. Edematous wall thickening of involved bowel segment and gross dilation of stomach & duodenum with stasis of contents suggestive of small bowel intussusception likely jejunojunal with intraluminal lipoma as lead point. HE shows abundant adipose cells suggestive of lipoma.

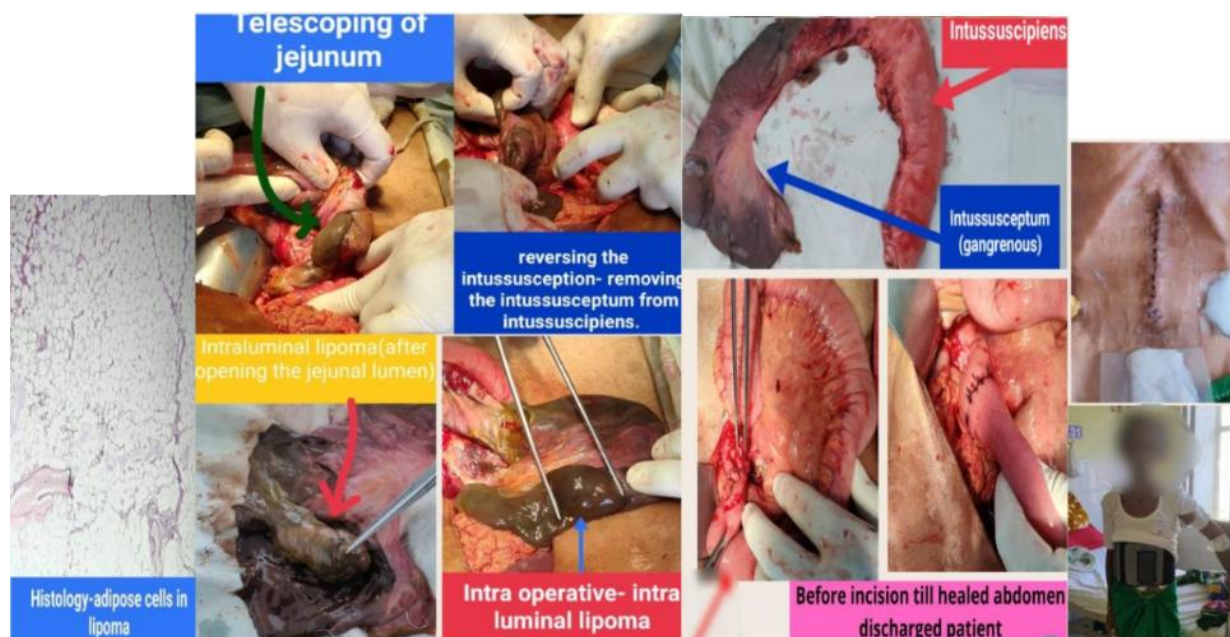
Lab Parameters

Hb-10.4g/dl, Na-139mmol/l

K 3.4mmol/l, Cr-3.2mg/dl and Alb-2.3g/dl

3. Treatment (9, 10)

Resuscitation of the patient in casualty (cannulation and IVF, catheterization and input/output monitoring, Nasogastric tube for stomach decompression, correction of hypo albuminemia and creatinine. Resection of gangrenous segment of jejunum (intussusceptum) along with lipoma (which was 60cm from the DJ junction) and duodenojejunal anastomosis. In post operative period orally allowed after 5 days and drain removed after 6 days, patient got discharged on day 10 after removing sutures.



Volume 12 Issue 9, September 2023

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4. Discussion

<i>Characteristics of Intussusception</i>	<i>Our Case</i>
<p>Common in infancy Ideopathic condition occurs due to hyperplasia of Peyer's patches in the ileum following viral gastroenteritis or upper respiratory tract infection. (or may have some pathological lead point such as Meckel's diverticulum, intestinal polyp, inflamed Intussusceptum (gangrenous) appendix or submucosal hemorrhage in Henoch-Histology adipose cells in Schonlein purpura.) Anterograde Presents with intestinal obstruction. •Commonly occurs in ileum. •Treated usually with reduction by hydrostatic pressure. (Resection and anastomosis in selected cases).</p>	<p>-Adult (elderly male patient) •Intraluminal lipoma as lead point. Retrograde type -Presented with Gastric outlet obstruction. •In proximal jejunum (jejunojejunal, 60cm from DJ junction). Managed with resection of gangrenous jejunal segment along with lipoma and duodenojejunal anastomosis.</p>

5. Conclusion

Adult bowel intussusception is a rare but challenging condition for the surgeon. Preoperative diagnosis is usually missed or delayed because of nonspecific and often subacute symptoms. This is an adult retrograde type of intussusception presented with gastric outlet obstruction with intra operative gangrenous jejunal segment which was treated by resection of gangrenous segment and duodenojejunal anastomosis.

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