A RARE CASE OF PROXIMAL JEJUNOJEJUNAL INTUSSUSCEPTION IN A YOUNG FEMALE

Ravi kumar Teppa*, Venkata Pavan Kumar Karanam*,1, Nandkishor Sopanrao Sude*, Vinay Kumar Salvadi* and Madan Haravu Srikantegowda*

*Department of General Surgery, ESIC medical college and hospital, Sanath nagar, Hyderabad, Telangana.

ABSTRACT Intestinal obstruction in adults due to intussusception is a rare entity and accounts for only 1% of all the causes. Jejunojejunal intussusception, and in particular occurring proximally, is rarely reported in the literature. Chronic and intermittent presentation of symptoms is a peculiar feature of adult intussusception. The nonspecific symptoms often lead to a late diagnosis. The clinical picture is confusing and poses a diagnostic challenge to the treating surgeon. We report a case of proximal jejunojejunal intussusception with an inflammatory polyp as a lead point in a young female.

KEYWORDS intussusception, jejunojejunal, polyp, proximal

Introduction

Adult intussusception represents 5%-16% of all cases of intussusception and 1%-5% of all cases of intestinal obstruction in adults [1]. In paediatric intussusceptions, 90% of cases are idiopathic, whereas 70%-90% of cases of adult intussusception are secondary to an underlying pathology, with approximately 65% being due to benign or malignant neoplasms[2]. Among adults, intussusceptions occurring in the most proximal part of the small bowel are rarely reported in the literature. We report a rare case of proximal jejunojejunal intussusception in a 24-year-old female with chronic symptoms.

Case report

A 24-year-old female was admitted with periumbilical pain radiating to the back of 3 days duration associated with nausea and bilious vomiting and obstipation. There was no history of fever and abdominal distension. She had no relevant history other than several similar episodes over the past 6 months, which had remitted spontaneously after conservative management at an elsewhere hospital.

General physical examination was within normal limits except for dehydration due to repeated vomiting. Abdominal examination revealed no abnormality. Ultrasonography of the abdomen showed a left hypochondriac complex, multilayered oval mass, with alternating hypechoic and echoic concentric rings suggestive of duodenojejunal intussusception. A CECT of the abdomen was done for confirmation of diagnosis, which showed telescoping of the proximal most jejunal loop along with mesentery and mild fluid into a jejunal loop, for a segment of 15-20 cm (Figure 1). Oral contrast is not seen beyond the duodenum. There is a thickening of intussuscipiens with thickened valvulae conniventes, suggestive of proximal jejunojejunal intussusception. The patient was taken up for emergency surgery. Laparotomy showed that the patient had proximal jejunojejunal intussusception around 15 cm from DJ flexure (Figure 2). Intussusception was reduced, and no ischemic changes in the bowel were noted. A lead point was palpable at the apex of intussusceptum. Enterotomy revealed a benign-looking polyp over that site, which was excised (Figure 3). Examination of the rest of the bowel revealed no other palpable swellings. The post-operative period was uneventful. Sutures were removed on 10th post-operative day. After 3 months of follow-up, the patient is asymptomatic.

Discussion

In intussusception, a portion of the proximal bowel (intussusceptum) invaginates into a more distal segment of the bowel (intussuscipiens). The progressive intussusception of the bowel leads to compression and angulation of the mesenteric vessels
Intussusception occurs most commonly during the first year of life, beginning at around 4 months and having a peak incidence at 8 months. Most intussusceptions in infants and toddlers are idiopathic and are without a clear lead point causing the intussusception. True anatomic lead points occur in only 2% to 10% of cases [3]. In contrast to children, intussusception in adults occurs secondary to a pathological lead point in 90% of cases. In adults, the lead points in the small-bowel intussusceptions are benign lesions (60%) and malignant (30%) lesions, while the rest (10%) are idiopathic [4]. Further, up to 66% of large bowel intussusceptions are caused by malignancy [4]. The more proximal location of intussusception and lead point being a benign inflammatory polyp is a rare combination encountered in our patient.

The typical presentation of intussusception is an infant or toddler who has the sudden onset of episodes of severe cyclical abdominal pain lasting 5 to 15 minutes. Adult intussusception has a variable presentation, and symptoms tend to be more chronic or intermittent. Common presenting features are vague abdominal pain (71%), nausea and vomiting (68%), abdominal distension with partial obstruction (45%) or palpable mass at physical examination [5].

Preoperative imaging aids in confirming intussusception and also could identify the lead point. In children, with a sensitivity of 98% to 100% and a specificity of 88% to 100%, ultrasound has become the primary modality of diagnosing intussusception [6]. A contrast CT scan is considered one of the best diagnostic tools with a diagnostic accuracy of 58–100% [7].

In children without features of peritonitis, reduction of the intussusception by air or contrast enema can be achieved with a success rate of 60% to 80% [8,9]. In adults, there is no role of conservative treatment as there is always an underlying lesion, which will lead to recurrence unless the offending lesion is removed. Definitive treatment depends on the type of lead point and status of the bowel intraoperatively. In recent years, laparoscopy has emerged as a potential tool with both diagnostic and therapeutic importance in managing adult intussusception [10].

Conclusion

Adult Intussusception is a rare entity, with 90% of the cases having a lead point. The variable presentation of this condition poses a diagnostic dilemma to the treating surgeon. Early use of modalities like CT scans may aid in confirming the diagnosis. Contrary to management in children, intussusception in adults always require surgical management. Expedited surgical intervention can prevent bowel ischemia. The decision whether to undertake resection or not should be tailored according to the underlying pathology identified intraoperatively.

Funding

This work did not receive any grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest

There are no conflicts of interest to declare by any of the authors of this study.
References


