CHRONIC INTUSSUSCEPTION DUE TO LIPOMATOUS POLYP IN ADULT PRESENTING AS INTESTINAL PERFORATION: A CASE REPORT

ABHESINH CHAUHANa, DEVI CHAUHANb, RAVI KOTECHA and S. P. CHOUHAND

abcDepartment of General Surgery, Kothari Medical And Research Institute, Bangla Nagar, NH15, Gajner Road, Bikaner, India

ABSTRACT

Intussusception in adult is a rare cause of intestinal obstruction. Its incidence is 5% of all cases of intussusceptions and 1 -5% of all obstruction in adults. We present a case of 60 year old gentleman presented with symptoms of colicky pain, nonbilious vomiting with duration of the 20 days. Initially abdomen pain was in lower abdomen but gradually spreading all over abdomen. After series of investigation patient found to have pneumoperitoneum. Exploratory laprotomy was performed. There was transverse colonic intussusception with multiple caecal perforation with discoloured serosal spots over the ascending colon. Therefore Right hemicolectomy was done. Histopathology report confirmed lipomatous polyp arising from the transverse colon just distal to the hepatic flexure. Usually local excision with colocolic anastomosis is sufficient. This patient had closed loop obstruction with pressure changes in caecum and ascending colon hence right hemicolectomy was done. Surgical resection is recommended to alleviate symptoms.

KEYWORDS: Intussusception, Lipomatous polyp, Pneumoperitoneum

CASE REPORT

60 year old gentleman presented with complained of colicky pain in right lower abdomen for last 20 days, which gradually become generalized and associated with one episode of vomiting containing gastric contents. Pain was relieved after defecation and after taking medication. He denied any history of altered bowel habits or constitutional symptoms. There was no family history of similar disease.

On examination, he was afebrile and dehydrated with tachycardia. Other vitals were normal. Abdomen was distented and mild tenderness present all over abdomen, but had no signs of rigidity and peritoneal inflammation. There was no mass or organomegaly elicited. Per rectal examination was normal. Abdominal pain radiograph showed dilated small bowels and right sided colon.

CT scan of abdomen was performed and shows free fluid in peritoneal cavity with fatty attenuation of about 42 mm in diameter in transverse colon. Dilated small bowel loops with air fluid levels were seen proximal to the lesion. CT appearance was consistent with intestinal perforation probably because of closed loop obstruction due to intussusceptions and lipomatous polyp as lead point.

Patient underwent exploratory laprotomy. Intraoperative findings showed dilated small bowel loops and right colon. Transverse Colocolic intussusceptions due to intraluminal growth was found with small perforation at apex of intussusceptions with multiple caecal perforation. Ascending colon had discolored serosal spots. We proceeded with right hemicolecetomy and ileocolic end to end anastomosis.

1Corresponding author
was done using hand sewn single layer interrupted 2-0 silk sutures.

Gross specimen dissected showed a large polyp in transverse colon distal to the hepatic flexure of about 5 x 2 cm with perforation at apex point of intussusceptions. Ascending colon was congested. Histopathological report confirmed lipomtous polyp arising from the transverse colon with no malignant changes.

Patient has uneventfull postoperative hospital stay and was discharged well 10 days after surgery.

DISCUSSION

Intussusception occurs when the proximal segment of an intestine (the intussusceptum) telescopes into the lumen of the adjacent distal segment of an intestine (the intussuscipiens). Intussusception is classified according to its anatomical location in enteric, ileocaecal, ileocolic and colocolic. Most intussusceptions in adults are due to a lead point, which is an identifiable pathological abnormality.

Adult intussusception is rare cause of intestinal obstruction and presents with variety of symptoms, most often consist with intestinal obstruction. Acute intestinal obstruction is not common and most patient present with subacute, chronic or intermittent symptoms. Classical clinical triad of abdominal pain, palpable sausage shaped mass and heme positive stool is rarely present. The mean age of presentation is around 50–60 years old. Male to female ratio is 1:1.3.

Colonic lipomas are rare benign tumors of the gastrointestinal tract and are classified as a type of benign non-epithelial tumor and its incidence is 0.2 to 4.4. Colonic lipoma is usually solitary and common being the ascending colon and cecum, followed by the transverse colon, descending colon, sigmoid colon and rectum. In majority, colonic lipomas are asymptomatic and do not require treatment, however, a small number may cause symptoms when the lesion is large,
particularly those with a diameter >2 cm. Colonic intussusception is also a rare complication of colonic lipoma. Their most common signs and symptoms include abdominal pain, bleeding per rectum, and alterations in bowel movements. They may also occur with such dramatic presentations as massive hemorrhage, intussusception, or even perforation, for which emergency operation is required. Ninety percent of colonic lipomas are localized to the submucosa and are rarely found in other layers of the bowel wall.

Several imaging modalities have been used to diagnose the intussusceptions. Takeuchi et al. report that computed tomography (CT) scan proved the most accurate modality to diagnose the intussusceptions followed by ultrasound. CT scan has a yield of 52% as compared to a yield of 32% for ultrasonography. Gastrointestinal contrast study is useful with a yield of 41% but usually not indicated in most cases of complete intestinal obstruction. Khan et al. quoted a diagnostic accuracy of CT scan of around 80% in diagnosing intussusception. Based on these results, Takeuchi et al. report that CT scan may be the first examination in a patient who presented with abdominal masses and nonspecific abdominal pain where intussusception is a possibility. The classical finding of a CT scan includes a target lesion or sign which represents the outer intussuscipiens and the inner intussusceptum, which is clearly visualized due to edematous bowels, otherwise also known as “double ring” or “coiled spring” appearance. As up to 90% of adult intussusceptions are due to underlying lesions, CT scan is more superior to ultrasonography in detecting such lesions.

Although treatment for adult intussusception is slightly controversial, it is well agreed by most authors that surgical intervention is unavoidable. In most cases surgical segmental resection is the most appropriate treatment. In cases where bowel wall is inflamed, ischaemic, or friable, it is advisable not to attempt manual reduction but to proceed directly with resection as it associated with increased risk of spillage or undetected mucosal necrosis leading to delayed perforation. Chronic intussusception may be difficult to reduce due to cross-scaring between intussusceptum and intussuscipiens. However, another viewholds that reduction of intussusception as much as safely possible followed by appropriate resection preserves bowel length in order to avoid short gut syndrome in case of intussusceptions involving small bowel.

Our patient presents with intestinal obstruction secondary to colocolic intussusception, with preoperative CT scan showing free fluid in peritoneal cavity with fatty attenuation of about 42 mm in diameter in transverse colon with dilated small bowel loops with air fluid levels were seen proximal to the lesion. CT appearance was consistent with intestinal perforation probably because of closed loop obstruction due to intussusceptions and lipomatous polyp as lead point. However, intraoperatively, Transverse Colocolic intussusceptions due to intraluminal growth was found with small perforation at apex of intussusceptions with multiple caecal perforation and ascending colon had discolorated serosal spots, decision was made to proceed with a right hemicolectomy without manual reduction. End-to-end ileocolic anastomosis on healthy bowel reduces the risk of anastomotic leak.

CONCLUSION

Adult intussusception remains a rare cause of persistent or intermittent chronic abdominal pain. Intussusception in adults is a different entity from children and it warrants a different approach in management. It is not common cause of intestinal obstruction in adult but need high suspicion of index especially when patients present with subacute or intermittent symptoms. Preoperative CT scan is needed for diagnosis purpose and preoperative planning. Most authors advocate segmental resection without attempt of manual reduction, as there is high risk of anastomotic complications of the manipulated friable and edematous bowel tissue involved.

REFERENCES


combined with other type of retroperitoneal liposarcoma. BMC Cancer, 10:239.


