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Case Report

Adult Jejunojejunal intussusception – submucosal hamartomatous polyp as a lead point

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Adult jejunojejunal intussusceptions are rare, accounting for only 5% of all cases of intussusceptions. They should be ruled out in patients with recurrent upper gastrointestinal obstructive symptoms. Lipomas, polyps, neurofibromas, leiomyomas, hemangiomas, hamartomas are benign lesions responsible for these cases. We present a 20 year old girl with recurrent pain abdomen, bilious vomiting secondary to jejunojejunal intussusceptions.

Key words: intussusceptions, jejunojejunal, adults

INTRODUCTION

Adult jejunojejunal Intussusceptions occurs when contracted proximal jejunum, the intussusceptum telescopes into relaxed jejunum distal to it, the intussuscipiens [1]. A proximal segment of bowel telescoping into distal segment is defined as ante grade and a distal segment into proximal segment as retrograde intussusceptions [2]. They account for 3% cases of intestinal obstruction and have definable pathological lead point in up to 90% of cases [3]. Majority of adult intussusceptions are enteric or ileocolic, with only one third being colocolic or colorectal [3].

It results from benign tumor in 40% cases, malignant in 17% and non neoplastic in remaining cases [1]. Predominant symptoms are of bowel obstruction. Rarely does it presents with abdominal mass or blood in stools [1]. Our case presented as upper gastrointestinal tract obstruction had sub mucosal polyp as lead point which could be removed by minilaparotomy.

CASE PRESENTATION

A 20 year old girl came with intermittent, colicky pain per umbilical region for one month, aggravated on food intake relieved with bilious vomiting. She had similar complaints two years back and was treated for gastritis. Except for mild tenderness in umbilical region abdominal examination was unremarkable. X-ray abdomen was normal. In view of recurrent symptoms diagnosis of upper gastrointestinal tract obstruction was made and CT scan abdomen done.

CT abdomen revealed jejunojejunal intussusceptions [Figure1,2]. Rest abdomen was normal. In view of low incidence of malignancy in small bowel intussusceptions, absent findings suggestive of malignancy on CT scan abdomen and diagnostic laparoscopy, jejunal loop with intussusceptions was brought out via mini laparotomy. Intussusceptions were reduced followed by enterotomy and excision of sub mucosal polyp [Figure3,4] . Rest small bowel was normal on palpation. Histopathology report came as hamartomatous polyp. Post operative period and follow up was uneventful.

DISCUSSION

Intussusceptions that involved jejunum or ileum are considered as enteric intussusceptions [4]. Acute symptoms are defined as < 4 days, sub acute 4 – 14 days and chronic >14 days [5]. Acute presentations represent only about 14% of cases of adult intussusceptions, with duration of symptoms usually exceeding one month and in many cases extending over many years [3].

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Figure 1: CT abdomen showing mesenteric fat and vessels interposed between an intussusceptum and the intussuscipiens.

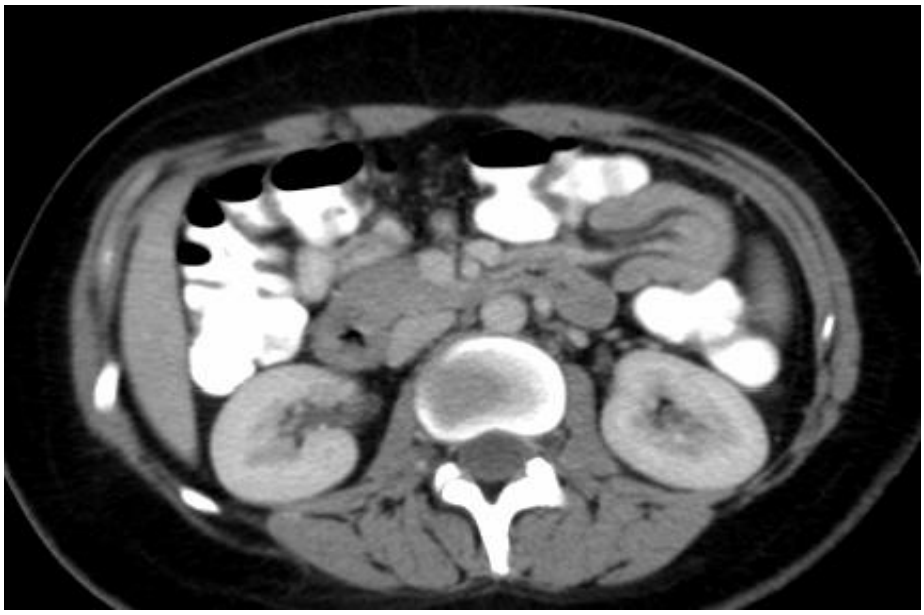
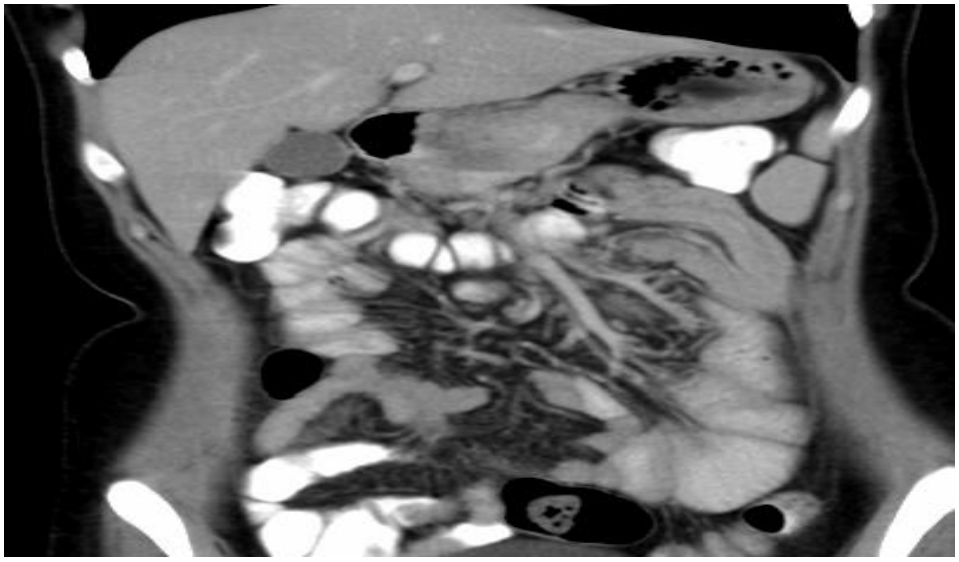


Figure 2: CT abdomen demonstrating a heterogeneous “sausage” mass with central low-attenuation fat being dragged into the intussuscipiens by the Intussusceptum.



Intussusceptions are preoperatively diagnosed by abdominal ultrasonography with the target and doughnut signs on transverse view and pseudo kidney sign in longitudinal view [4]. As most adult intussusceptions present with intestinal obstruction ultrasound abdomen is apt to be masked by gas filled bowel loops [6].

CT scan abdomen is investigation of choice showing sausage shaped mass on longitudinal section and target lesion in cross section. Approximately two-third of colonic cases have malignant basis compared to one-fourth of enteric types so resection surgery without reduction remain the mainstay of treatment for colonic intussusceptions.

Reduction should be attempted to allow delayed elective surgery on prepared bowel or avoidance of an abdominoperineal resection [3]. Objection to reduction are intraluminal seedling, venous dissemination of

Figure 3: showing jejunojejunal intussusceptions

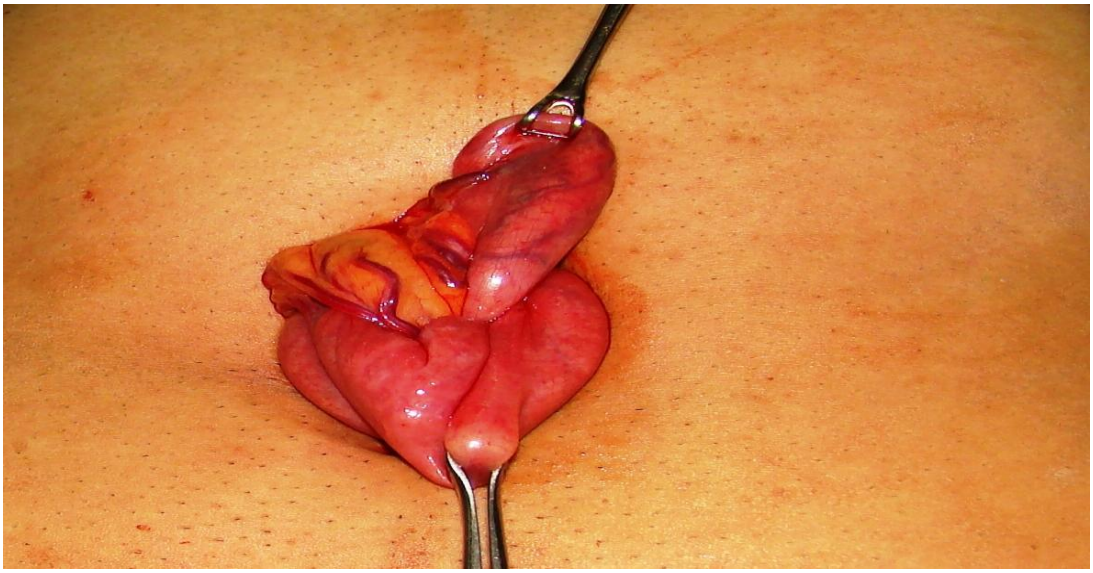
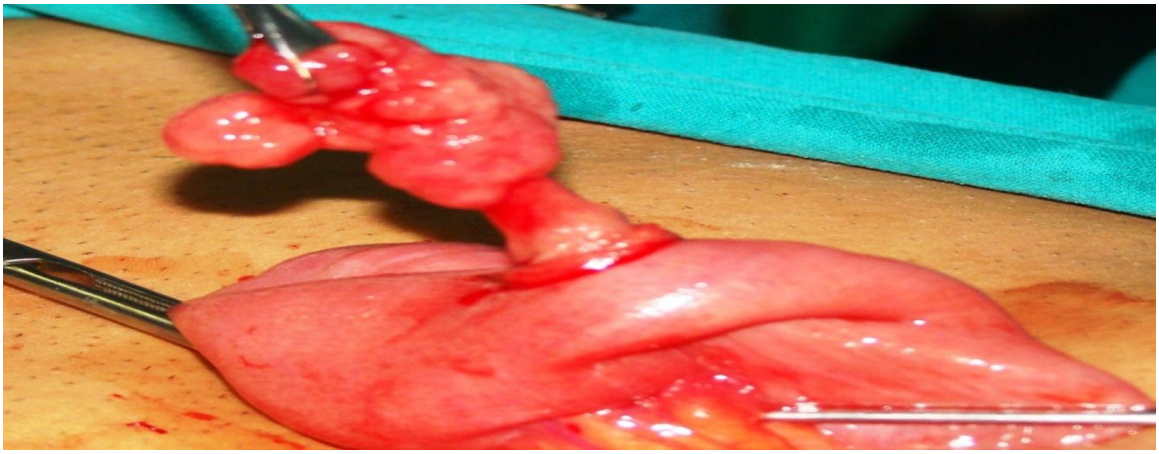


Figure 4: showing enterotomy and excision of sub mucosal polyp.



malignant cells, perforation during manipulation and increased risk of anastomotic complications in face of edematous and inflamed bowel. Reduction before resection should be favored in enteric type due to low incidence of malignancy [4].

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