Adult intussusception. CT diagnosis

M. C. Casamayor Franco, C. Yáñez Benítez, E. Hernando Almudí, L. A. Ligorred Padilla, A. García Omedes, J. I. López López1 and F. Baque Sanz

General Surgery, Gastroenterology, and Radiology Departments. San Jorge Hospital. Huesca, Spain

Intestinal invagination is frequently seen in infants, but only 5% of cases are seen in the adult. It represents 1-5% of all causes of bowel obstruction (1). We report the case of a 71-year-old woman with a past medical history of fracture to the radius who arrived in our emergency department complaining of 2-day-standing abdominal distension secondary to bowel obstruction. Blood tests revealed a high leukocyte count with neutrophilia, and gas-fluid levels were seen in the small bowel on abdominal radiographs. After spontaneous resolution without surgery a colonoscopy was performed, which revealed a large, 60-cm adenomatous polyp from the anal verge. A sample was taken for biopsy, which showed a tissue compatible with colon adenocarcinoma. A computed tomography scan identified an atypical distribution of the small bowel and stomach, and also clear signs of invagination (Fig. 1). A surgical procedure was performed, which found an ileocecocolic invagination secondary to a voluminous tumor in the cecum. After invagination reduction a right hemicolectomy was performed, with an uneventful post-surgical period. In adults intestinal invagination usually presents in a subacute or chronic form with nonspecific symptoms; abdominal pain is the most frequent symptom (1,2) and is rarely associated with mechanical bowel obstruction (1,2). Computed tomography has proven to be extraordinarily sensitive for the diagnosis (78%) (3) specially of chronic cases, and may identify the invaginated bowel surrounded by mesenteric fat as well as mesenteric vessels within the invaginating segment (3,4). All authors agree that surgical resection is the treatment of choice (1,5) because there is almost always an organic cause in the adult (80-90%) that acts as an invaginating head (1,2). Malignant tumors, adenocarcinomas or lymphomas arising in the ileocecal valve represent the most frequent cause of invagination (65%) (2,3). There is controversy in the literature reviewed regarding whether mechanical reduction should be attempted prior to or during surgery (2,5). Some authors think that this can cause tumoral embolization or intraluminal dissemination, and also elevates the risk of bowel wall perforation from unnoticed mucosal necrosis (5).

REFERENCES