

A Rare Case Of Intermittent Ileocecal Intussusception Due To Meckel's Diverticulum

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Abstract

Intussusception represents 1% of all bowel obstructions that are admitted to hospitals.

Aetiology of intussusceptions in adults is a different entity compared to children. In children the causes are usually due to abnormality in development and function whereas in adults most often an underlying neoplasm is the causative agent.

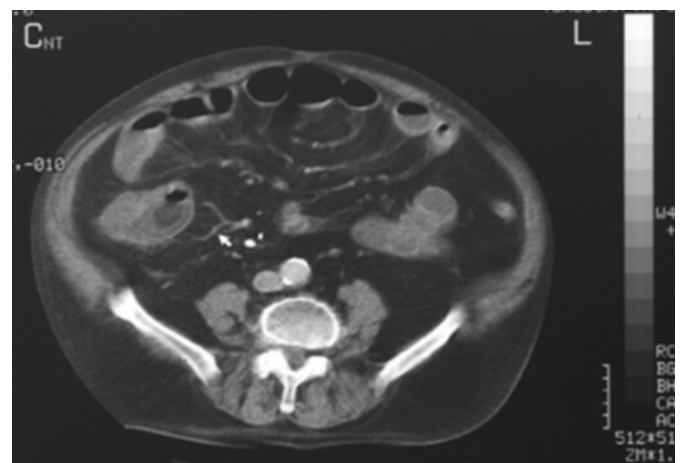
Furthermore they can broadly be classified as primary and secondary with primary having more often an acute presentation. Primary being idiopathic and secondary being more commonly due to neoplastic lesions.

CASE REPORT

A 74 year old gentleman presented to A&E with one day history of intermittent central abdominal pain relieved either by passing small amounts of loose stools or flatus. This was associated with vomiting. Prior to this symptom he had constipation for 5 days. There was no history of previous abdominal operations. His past medical history included angina and chronic obstructive airway disease.

On admission clinical examination and blood results were all normal. However abdominal imaging (X-ray) showed some dilatation of small intestine. On account of these findings, a provisional diagnosis of partial small bowel obstruction was made and he responded partially to the conservative management i.e, intravenous fluid and nasogastric tube. On the 4th day of admission, it was noted that his abdomen was distended and was diffusely tender with shifting dullness. The computer assisted tomographic scan of his abdomen showed thickened terminal ileum consistent with intermittent ileocolic intussusception (fig 1).

Figure 1



As a result of his clinical condition and CT scan findings, he underwent emergency exploratory laparotomy where we found thickened terminal ileum and its mesentery. The caecum was thinned out and serosal surface looked necrotic which would be consistent with a recent ileo caecal intussusception. There was no obvious intussusception was found per operatively. Therefore a right hemicolectomy including the Meckel's diverticulum was performed. The specimen revealed extensive ileocaecal ischaemic change, in association with the development of an intussusception, but no evidence of dysplasia or malignancy. Post operatively he made a good recovery and was discharged to community hospital for convalescence.

DISCUSSION

The first report of intussusception was made in 1674 by

Barbette of Amsterdam (1)

Intussusception has also been noted in patients with tropical sprue/coeliac disease (2), abdominal trauma (3), and during the postoperative period.

The presenting symptoms in adult patients with intussusceptions are non-specific and often long standing. Most report pain as the commonest symptom, being present in more than 70% of patients, with vomiting, similar to any other kind of intestinal obstruction.

The common intussusceptions have been classified into four categories according to the site of origin and they are: enteric, ileocolic, ileocaecal, and colonic (3). However, in clinical practice it is difficult to differentiate between ileocolic and ileocaecal intussusceptions.

Computed tomography seems to be the most reliable investigation in making a preoperative diagnosis, especially in those patients with non-specific abdominal pain in whom the diagnosis can be elusive (4). This case also stresses on the importance of timely CT scan during the occurrence of symptoms. The other investigation that has shown equivocal results is the contrast studies such as barium enema.

CONCLUSION

Intussusception in adults is an infrequent clinical problem.

The diagnosis of this condition can be difficult as symptoms are often non-specific. It is important to have a high index of suspicion. The most useful investigation is abdominal computed tomography. Treatment requires resection of the involved segment of bowel including any lesions that might have been the cause of intussusception.

References

1. Barbette P. Oeuvres Chirurgiques et Anatomiques. Geneva: Francois Miegé, 1674.
2. Felix EL, Cohen MH, Bernstein AD, et al. Adult intussusception: case report of recurrent intussusception and review of the literature. *Am J Surg* 1976;131:758-61.
3. Brooks A, Bebington BD, Lucas S, et al. Intussusception caused by blunt abdominal trauma. *J Trauma* 1999;47:156-7.
4. Gayer G, Apter S, Hofmann C, et al. Intussusception in adults: CT diagnosis. *Clin Radiol* 1998;53:53-7.
5. Weillbaecher D, Bolin JA, Hearn D, et al. Intussusception in adults: Review of 160 cases. *Am J Surg* 1971;121:531-5
6. Dolan K, Khan S, Goldring JR. Colo-colonic intussusception due to lipoma. *J R Soc Med.* 1998 Feb; 91(2): 94
7. Bond MR, Roberts JB. intussusception in the adult. *Br J Surg.* 1964 Nov;51:818-825. Burmeister RW. Intussusception in the adult; an elusive cause of recurrent abdominal pain. *Am J Dig Dis.* 1962 Apr;7:360-374.
8. Murdoch RW, Wallace JR. Adult intussusception in Glasgow 1968-74. *Br J Surg.* 1977 Sep;64(9):679-680.
9. Stubenbord WT, Thorbjarnarson B. Intussusception in adults. *Ann Surg.* 1970 Aug;172(2):306-310.
10. Eliot, Ellsworth., Jr. Corcoran, James A. II. Intussusception, with Special Reference to Adults. *Ann Surg.* 1911 Feb;53(2):169-222.
11. Whimster WF. Idiopathic intussusception in the adult. *Lancet.* 1963 Apr 20;1:887

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