

Dual Pathology Of Idiopathic Caecotransverse Intussusception And Rectosigmoid Carcinoma In A 69 Year Old

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Citation

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Abstract

Intussusception as a cause of intestinal obstruction in adults is a rare finding and constitutes only 10-15 % cases. We report a case of a 69 yr old gentleman who had presented with symptoms of acute intestinal obstruction and was diagnosed to have idiopathic caeco-colic intussusception extending up to the transverse colon and a rectosigmoid carcinoma. He was treated by a double resection and anastomosis of large bowel. Elderly patients with intestinal obstruction and history of loss of weight and recent change in bowel habits are always prone to have significant , but often silent pathologies like malignancies related to the bowels and should always be considered even after finding out more apparent causes for the obstruction.

CASE REPORT

A 69 yr old patient presented to the surgical department with features of acute intestinal obstruction associated with absolute constipation since last 48 hours, profuse bilious vomiting and moderate dehydration. He had a two weeks history of slight periumbilical and right lower abdominal pain with intermittent episodes of diarrhoea and p/r bleed , recent loss of 10 kgs of weight with decreased appetite over last few months. He had a past history of diverticular disease and appendectomy.

On examination, his abdomen was distended and nontender, and bowel sounds were diminished. On P/R examination there was slight stool but no evidence of any mass or blood.

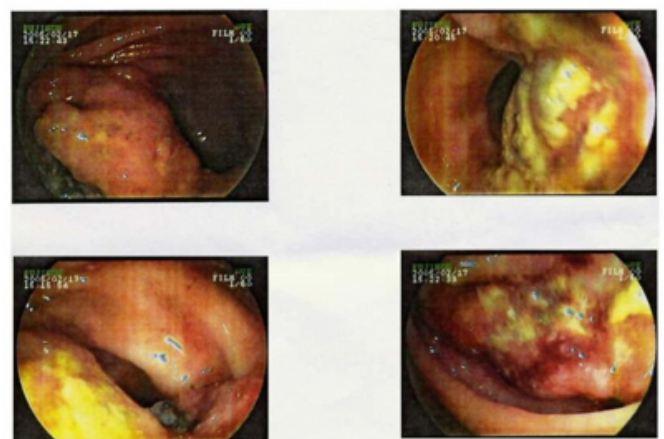
He was afebrile and had raised White cell counts (17.5 with neutrophils of 82%) decreased Haemoglobin levels (10.2 gm%) and the CRP was >180. On an abdominal xray distended small bowel loops were identified. In the view of his age and his past symptoms of weight loss and P/R bleed he underwent an urgent CT scan of abdomen and a sigmoidoscopy soon after admission.

A CT scan revealed caeco transverse intussusception with lead point being the hepatic flexure. The tip of intussusceptum extended till the mid transverse colon. There were several enlarged mesenteric nodes, largest being 13 mm in size.

On sigmoidoscopy a large growth was visible at 20 cm, just beyond the rectosigmoid junction. This was partially obstructing. No biopsies were taken as the patient was on Warfarin (INR 2.5) for atrial fibrillation.

Figure 1

Sigmoidoscopy pictures
showing Partially obstructing rectosigmoid mass.

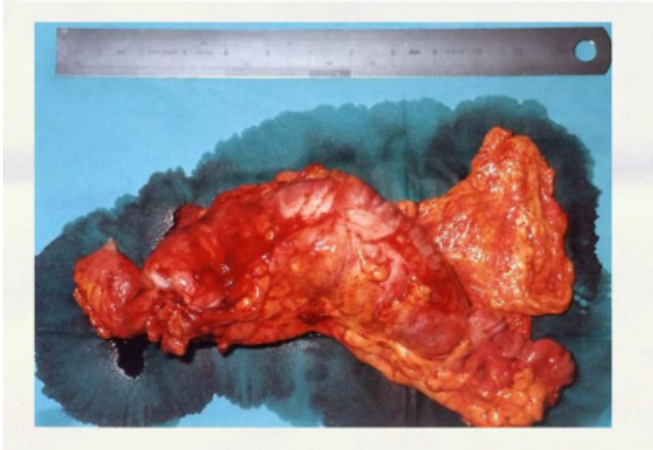


Findings at laparotomy were “caeco-transverse intussusception” extending from distal half of caecum to the midtransverse colon, the ileo caecal junction being visible proximal to it with bleeding at appendicular area.(appendectomy in past). Attempts of reducing the intussusception were unsuccessful due to gross adherence.

There was obvious tumour in the rectosigmoid at the level of sacral promontory which appeared relatively free with enlarged lymphnodes in mesorectum. Sigmoid colon had multiple diverticulae. There was blood stained fluid in the pelvis. Liver was clear to feel.

Figure 2

Operative specimen of the intussusception mass involving caecum to the mid transverse colon.....



Plan of double resection and anastomosis was undertaken to avoid total colectomy and ileoanal anastomosis which would have resulted to cumbersome diarrhoea. Right hemicolectomy from the terminal ileum to mid transverse colon, proximal to middle colic artery supply, was performed, followed by side to side ileo – transverse anastomosis. The rectosigmoid was resected with adequate clearance distal to tumour mass and a colo-rectal anastomosis was performed.

The histopathology showed:

1. The right hemicolectomy specimen with Caeco-Transverse Intussusception. Microscopic features- Colonic wall of intussusceptum showed features of chronic ischemia involving all layers with extensive necrosis at the head of intussusceptum. No tumours were apparent and diagnosis was Idiopathic caeco-transverse intussusception.
2. The high anterior resection specimen showed a moderately differentiated adenocarcinoma of the colon .Tumour had infiltrated through muscularis propria. One lymph node showed tumour cells.

There were no signs of distant metastasis.

DISCUSSION

Intussusception is a condition where a proximal segment of gut invaginates into an immediate distal segment. The entering inner tube is intussuscepted, returning segment is the middle tube and the distal segment being the outer tube or intussusciens. The advancing part of the inner tube is the apex . This total mass is the intussusception and the neck is the junction of the proximal gut and the intussusception. The inner tube often becomes ischemic, which is directly proportional to the neck tightness. Symptoms are related to the intestinal obstruction and to the ischemia. In advanced cases ischemia can lead to endogenous sepsis. The causes “in adults” are mostly related to a mass at the “apex” which in most cases (>50%) are carcinomas or polyps. In about 8-10% cases no apparent causes are found and are categorized as idiopathic.

In our case, the presentation was of an acute intestinal obstruction due to idiopathic intussusception . The caecum distal to the ileocaecal junction had invaginated into the ascending colon and the intussusception extended up to mid transverse colon. No neoplasm was found at the “apex” by histopathological studies. CT scan and a sigmoidoscopy showed a second pathology in the rectosigmoid area which was later proved to be a Duke's C (pT3N1M0) rectosigmoid adenocarcinoma by histopathological analysis . The intervening segment of gut from mid transverse colon to the proximal sigmoid was healthy. A double resection and anastomosis was thus successfully performed and was expected to play a role in alleviating the cumbersome diarrhoea.

CONCLUSION

Elderly patients with intestinal obstruction and history of loss of weight and recent change in bowel habits are always prone to have significant, but often silent pathologies like malignancies related to the bowels and should always be considered even after finding out more apparent causes for the obstruction.

References

1. Intussusception in Adults , AJR Am J Roentgenol. 1986 Mar;146(3):527-31.
2. Bailey and Love' s Short Practice of Surgery 24th Edition

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