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Original Research Article

Intussusception in Elderly Patient with Classical Triad of Presentation-A Case Report

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Abstract

Intussusception is the invagination of one segment of the bowel into another. It is common in children, rare in the elderly age group (1). Most of the causes in children are idiopathic whereas leading point pathology exists in the elderly age group[2]. In 54–69% of adult cases, the precipitating cause is bowel malignancy [3]. We are presenting a case high level of suspicion was required to reach at the diagnosis as the patient has only complaint of intermittent pain for the last 20 days relieved on taking analgesic and has passed mucous mixed bloody diarrhoea 2 days back with no history of nausea or fever.

Introduction

Intussusception is invagination of one segment of the bowel into another. It is common in children, rare in elderly age group [1]. Most of causes in children are idiopathic whereas leading point pathology exists in elderly age group [2]. In 54–69% of adult cases, the precipitating cause is bowel malignancy [3]. We are presenting a case high level of suspicion was required to reach at the diagnosis as patient has only complaint of intermittent pain for last 20 days relieved on taking analgesic and has passed mucous mixed bloody diarrhoea 2 days back with no history of nausea or fever.

Case summary

A 51 year old lady presented in OPD With complaint of on and off pain and distention of abdomen for last 20 days. Pain was colicky in nature, severity of pain has decreased with due course of time, she used to take analgesic from local doctor in the meantime. Pain was not associated with nausea or vomiting. Prior to admission in our hospital 2 days before patient passed mucous mixed blood twice associated with colicky peri umbilical pain. Patients appetite has decreased with due course of time. Patients have no any co-morbidities, significant urinary symptoms or surgical history.

On physical examination patient has pallor, rest of physical examination was unremarkable. On Per abdomen examination a well-defined non tender lump felt in the Right lumber region. PR examination revealed empty rectum with soiling of finger with non-offensive mucous mixed blood.

Investigations

Abdominal x ray erect posture was unremarkable. USG whole abdomen was

suggestive of ileocolic intussusception (Figure-1)

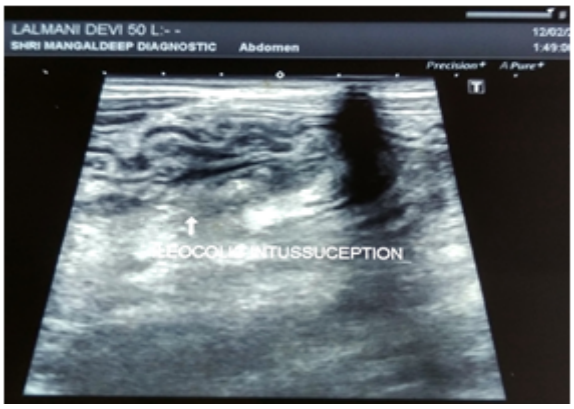

Figure 1: USG showing ileo-colic intussusception (white arrow)

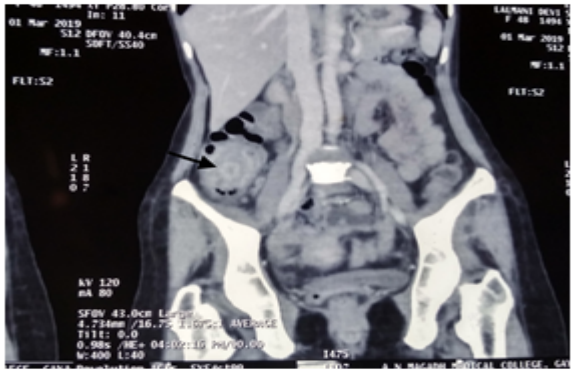

Figure 2: CT Abdomen showing Characteristic 'target sign' (Black Arrow)

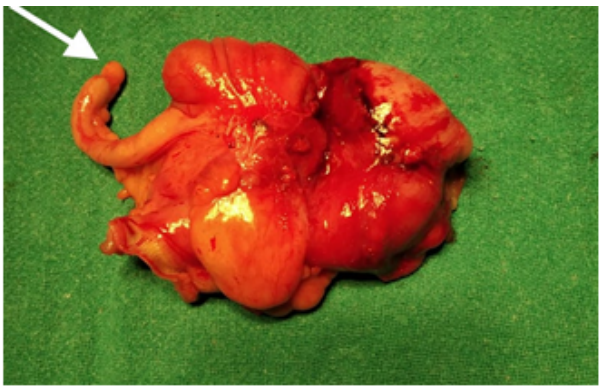

Figure 3: Resected cecum including intussusception segment and appendix (white arrow)

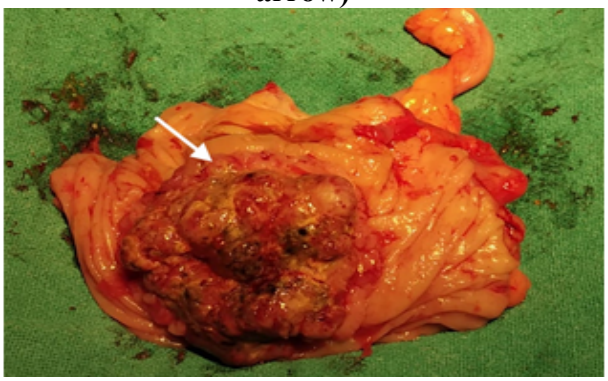

Figure 4: Cut open specimen of intussusception segment showing fungating mass (white arrow)

A CT pelvis and abdomen with contrast scan was done , distal part of ileum seen entering the lumen of the caecum with moderate dilatation of caecum with mild mural stratification, no evidence of significant lymph node enlargement in the right iliac fossa. The characteristic 'target sign' seen in figure 2 with the edematous outerrim. Patients routine blood test was within normal limit. Exploratory laparotomy done in emergency department, small bowel loop was mildly dilated. There was partial passable obstruction due to ileocolic intussusception which felt like hard mass, it was no possible to reduce. Resection of cecum and distal ileum was done including the intussusception segment. Ileo-ascending end to end anastomosis done. Gross ileo-caecal mass containing appendix (figure.3) and Cut open specimen of the segment showing fungating mass (figure-4).

Course during hospital stay was uneventful, discharged from hospital on POD 8. During follow up period histopathology report came to be DUKE class A N2 NO MX. Pt was tolerating well per-orally pt was called for chemotherapy.

Discussion

Intussusception is invagination of one segment of bowel into another. It is common in children, rare in elderly age group [1]. Adult intussusceptions account for less than 5% of all cases [7].

Most of causes in children are idiopathic whereas leading point pathology exists in elderly age group [2]. In 54–69% of adult cases, the precipitating cause is bowel malignancy [3].

The classical presentation triad of abdominal pain, palpable abdominal mass and bloody stool is seen in only 9.8% of adult cases [4]. The symptoms and signs currently described in the literature are very non-specific: nausea, gastrointestinal bleeding, and change in bowel habits, vomiting and constipation [5]. Because of the complications can be potentially life threatening adverse effects so, early diagnosis and treatment is very important.

In our case patient had intermittent abdominal pain that appeared to settle quickly with simple analgesia. The current literature suggests that pain is the commonest symptom being present in 71–90% of patients [6].

Conclusion

In adults high degree of suspicion is required for making diagnosis as intussusception is rare among elderly. In our patient the classical presentation triad abdominal pain, palpable abdominal mass and bloody stool was seen which is present in only 9.8% of adult cases.

CT can be considered a diagnostic tool to plan the operative procedure. In adult require early exploratory laparotomy once diagnosis has been made. Adequate bowel resection is required as in 54-69% of cases causes are bowel malignancy [7]. Follow up is needed, never attempt to reduce intussuception until pathological cause has been ruled out.

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