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Adult Intussusception: Keep a Close Eye on the Telescope

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INTRODUCTION

Intussusception is a condition in which part of the bowel invaginates or telescopes into itself; most commonly seen in infants ages 3 months to 2 years. The overall incidence in adults represents 5% of all cases[1]. It is considered a medical abdominal emergency as it may result in a small bowel obstruction, peritonitis or bowel perforation. The most common presenting symptom is intermittent abdominal pain. Other symptoms include nausea, vomiting, fever, and bloody “currant jelly” stool.

CASE PRESENTATION

A 26-year-old female with no medical history presented to the emergency room with subjective fevers, non-bloody, nonbilious vomiting, colicky abdominal pain, and watery non-bloody diarrhea for two days. She was recently seen and treated for gastroenteritis at an urgent care center, however continued to have symptoms. She endorsed similar symptoms one month ago, which resolved on their own. Vitals were significant for tachycardia (127 bpm) and fever (102.8F). Laboratory results were normal and pregnancy test was negative. She appeared in distress; she had rigors, was dry heaving and complained of extreme nausea. She endorsed diffuse abdominal tenderness on exam.

She received antibiotics, pain medication, and antiemetics. A CT abdomen/pelvis with contrast was obtained for suspicion of appendicitis. Results revealed in figure 1.

CASE PRESENTATION cont.

Serial abdominal examinations were performed along with bowel rest and we observed for self-resolution. Stool culture, blood culture, C. diff antigens and HIV Ag/Ab were negative. 48 hours later, she was advanced to a clear liquid diet. She endorsed nausea after drinking despite antiemetic medication. Because of persistent symptoms, a repeat CT scan was obtained to evaluate development of an obstruction. Results demonstrated interval resolution of the previously visualized jejuno-jejunal intussusception. After 72 hours, with no intervention, her abdominal pain improved; she was afebrile and was able to tolerate solid foods.

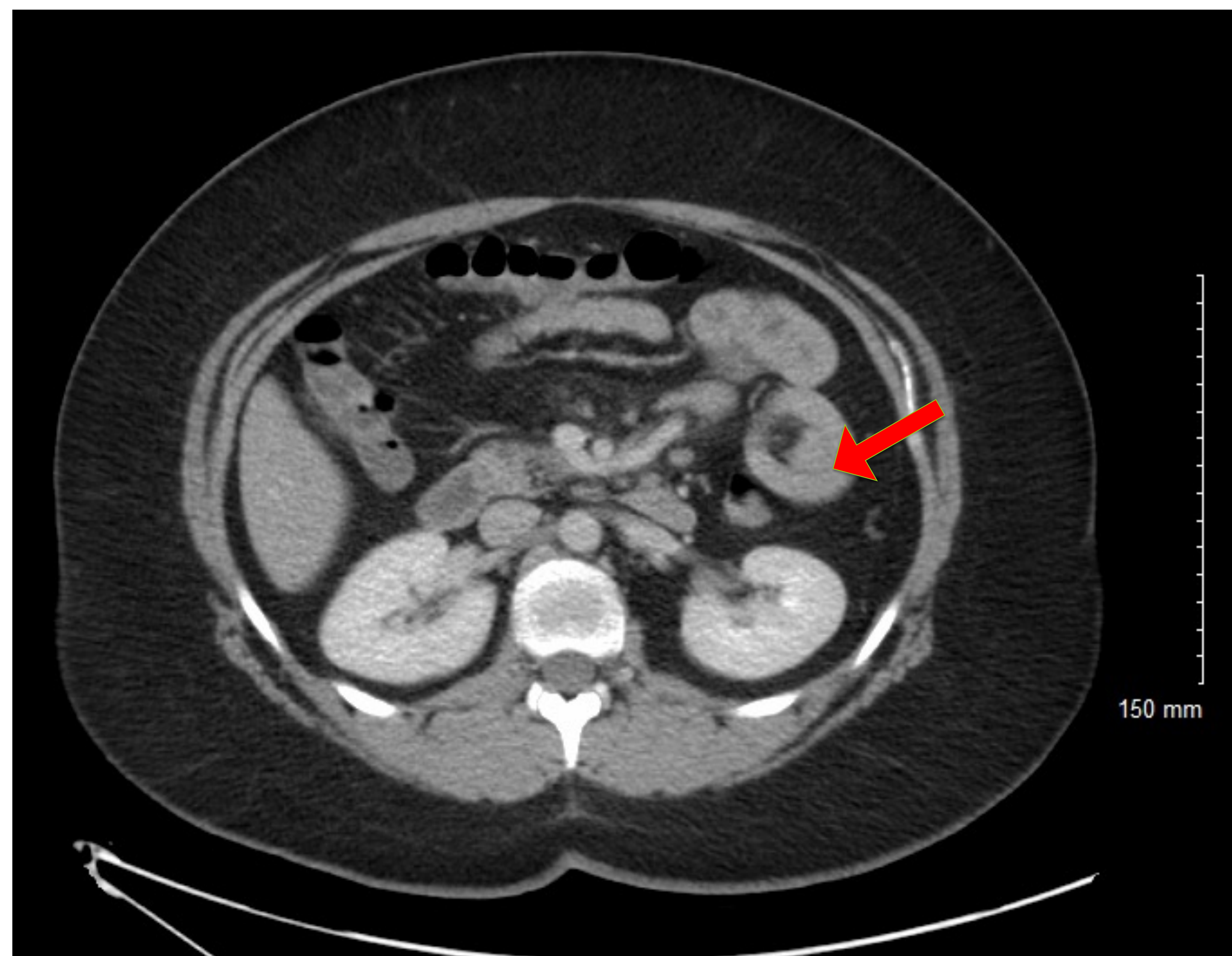

Figure 1. CT abdomen/pelvis demonstrating mild sclerosing mesenteritis and short segment jejuno-jejunal intussusception measuring 4.4 cm in length without evidence of inflammation, stranding or bowel obstruction.

DISCUSSION

Intussusception is commonly overlooked in adults as the diagnosis is unusual in this patient population. The exact mechanism of bowel intussusception is unknown. 8%-20% of cases are primary or idiopathic and more likely to occur in the small intestine. Majority of cases in adults are believed to be secondary intussusception; initiated from a pathological lesion of the bowel wall or irritant within the lumen that alters normal peristalsis[2]. Common risk factors include endometriosis, bowel adhesions, malignancy, polyps, and AIDS[3].

Diagnosis is with CT; distended loop of bowel appears thickened as it contains two bowel layers. A "target sign" may be seen on the sagittal view of the abdominal CT, while on axial or coronal view, the intussusception will appear as a sausage-shaped mass. However, it can occur without any obvious lead point. Treatment includes supportive care and bowel rest. Surgery should be considered if complicated by obstruction or caused secondary to malignancy.

REFERENCES

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