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Intussusception Due to A Tumour of The Left Colic Angle: Case Report

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1. Summary

1.1. Introduction

Acute intussusception (AI) is a rare condition in adults. The colon is less frequently affected. The cause is often organic. We report a case of intussusception due to a colonic tumour.

1.2. Case Report

A 65-year-old woman with no prior medical history presented with an obstructive syndrome. On examination, her level of consciousness and hemodynamic parameters were stable. Her abdomen was moderately distended, with a mass in the left iliac fossa. A CT scan revealed an intussusception of the colon. Surgery revealed an intussusception due to a tumour in the left colic flexure. We performed a segmental colectomy without reduction and colostomy. Histopathology confirmed a well-differentiated adenocarcinoma (pT3N1M0). Staging investigations showed no residual tumour or metastases. Chemotherapy was administered.

1.3. Conclusion

In adults, intussusception often masks a tumour. Resection of the intussuscepted pouch without reductionism the rule.

2. Introduction

In adults, intestinal obstruction (IIA) is a rare condition. It accounts for 1 to 5% of intestinal obstructions [1,2]. Its location is most often the ileum; more rarely the colon is affected [3]. Emergency diagnosis of obstruction or peritonitis is rare [2]. The cause is organic in 70 to 90% of cases, and may or may not be tumoral. Treatment in adults is based on resection [4].

3. Case Presentation

A 65-year-old woman, with no particular medical history, was admitted to the emergency room for moderate pain (6/10 VAS) in the left iliac fossa, cramp-like, associated with two episodes of vomiting of food, with cessation of bowel movements and gas, which had been occurring for 3 days, against a background of chronic constipation.

She presented with normal consciousness (Glasgow 15/15); a blood pressure of 156/110 mmHg; a pulse of 101 beats/min, a temperature of 36 °C, a postprandial blood glucose of 1.37 g/dl and an oxygen saturation of 100% in room air.

The abdomen was moderately distended, contributing to respiration. Tenderness and a hard, mobile mass were noted in the left iliac fossa, there was no umbilical tenderness, and the rectal ampulla was empty. The white blood cell count was 8100/mm³; haemoglobin 13 g/dL; platelet count 419,000/mm³; creatinine 10 mg/L; sodium 131.8 mmol/L; potassium 3.5 mmol/L; and CRP < 6 mg/L.

The abdominal CT scan showed an intussusception of the descending colon over 12 cm, without signs of digestive ischemia, with a few subcontinental lymph nodes, moderate distension of the colon upstream (59 mm) as well as of the small bowel (35 mm) (Figure 1).

Emergency resuscitation measures have been implemented.

The laparotomy revealed an intussusception due to a tumour of the left colic angle, measuring approximately 5 cm (Figure 2a). The spleen and liver were normal; there was no ascites or peritoneal carcinomatosis.

We performed a high segmental colectomy without reduction of the colostomy tube, combined with a Bouilly-Wolkman colostomy (Figure 2b/2c/2d). The postoperative course was favourable, with a viable and productive stoma, and the patient was discharged home after 3 days.

The CT scan of the chest, abdomen, and pelvis showed no residual tumour or metastasis, and the total colonoscopy revealed a healthy colonic mucosa. Histopathology confirmed a well-differentiated adenocarcinoma, infiltrating the serosa without extending beyond it, with two of twelve lymph nodes involved; the resection margins were clear, classified as pT3N1M0 according to the AJCC, 8th edition (2017).

Follow-up in medical oncology for adjuvant chemotherapy was initiated. The patient was seen again after 3 months with good clinical progress.

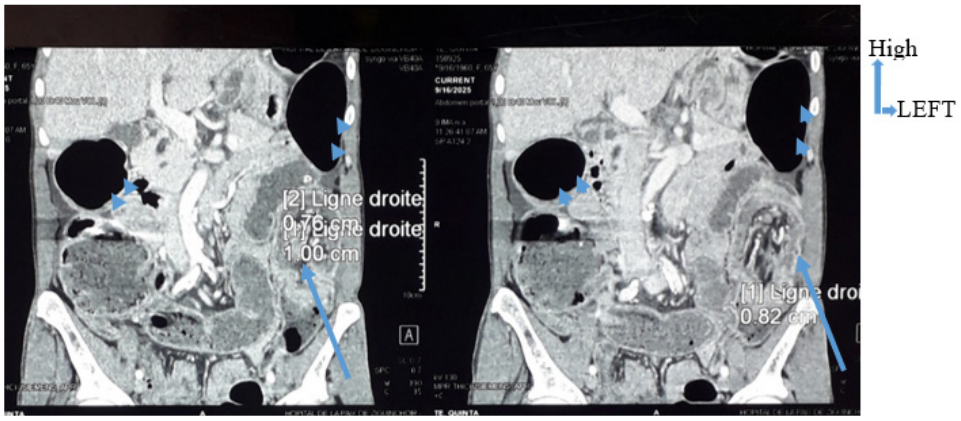

Figure 1: frontal section of abdominal CT scan showing acolonic distension (arrowhead), with thickening of the wall and a roll of colonic intussusception (arrow).

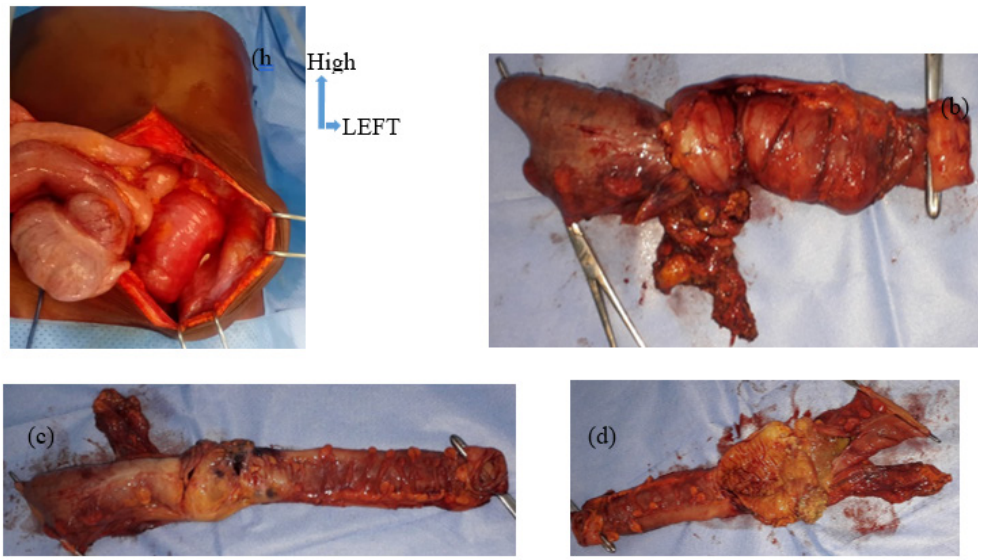

Figure 2 : intraoperative images

(a) : Small bowel tumor 100 cm from the ileocecal junction.

(b) : Surgical component of the intussusception roll

(c) : Invaginated sausage

(d) : Tissue tumor, ulcero-budding, measuring 4×3 cm, located 8 cm and 18 cm from the extremities.

4. Discussion

Intussusception is responsible for obstruction in adults in 1 to 5% of cases; the obstruction is organic in 70 to 90% of cases [1]. It most often affects the ileum and rarely the colon; when it occurs in the colon, it is located in the right colon in 40 to 85% of cases [5]. The average age reported in the literature is between 40 and 50 years old [1]. The symptoms are nonspecific and often misleading : bowel obstruction or nonspecific abdominal pain [1]. Some types of intussusceptions can mimic appendicitis [6]. When the subcutaneous fat or bloating is not too significant, or in cases of sufficient muscle relaxation, palpation of the intussusception is possible, found in 24 to 42% of cases [7,8]. In adults, the triad of paroxysmal abdominal pain, bloody diarrhoea, and a palpable mass is present in less than 9.8% of cases [6]. Laboratory tests do not guide the diagnosis, but are useful for assessing the impact. Abdominal ultrasound is unequivocal in the diagnostic strategy for intussusception in children. It provides the diagnosis in approximately 60% of cases in adults [4].

Abdominal CT scan remains the examination of choice with a sensitivity of 58 to 100%, allowing confirmation of the diagnosis, localization of the intussusception, identification of its cause and assessment of visceral damage [4.9]. Intraoperative diagnosis of intussusception is also possible and the surgeon must keep in mind, as reported in the observation of Anoh NA [5]. In adults, the treatment of an intussusception is always surgical; the authors agree on the necessity of a primary en bloc resection without reduction, in order to limit the risks of septic contamination and tumour seeding [1,2]. Reduction by hyper pressure is contraindicated due to the frequency of tumorous causes [10,11]. The most common malignant tumours involved are: adenocarcinomas, lymphomas, carcinoids, leiomyosarcomas, and metastases [4]. Mortality from intussusception in adults is significant and varies depending on the ethology, the patient's underlying health, and the severity of the lesions [4].

5. Conclusion

In adults, intussusception most often masks an underlying tumour. The presentation as an obstruction makes diagnosis straightforward. Resection of the intussuscepted portion without reduction is the standard procedure. The prognosis depends primarily on the promptness of intervention, but also on the stage of progression of the underlying lesion.

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