

Colo-Colonic Intussusception

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Abstract

When evaluating a young woman with abdominal pain, it is paramount to keep a broad differential. When considering intussusception, we usually think of a bimodal distribution, occurring at the extremes of age. In adult patients intussusception is usually secondary to a lead point, most commonly a mass. Temporizing treatments options exist, however, only surgery provides a definitive cure.

Case Report

35 y/o female presented with mild, pressure-like, intermittent, non-radiating abdominal pain for two weeks. Location was initially LLQ however on presentation the pain was diffuse. Patient admits to anorexia, recent five pound weight loss, intermittent diarrhoea and brown stool mixed with blood, however denies fever, chills, nausea, and vomiting, and GU symptoms. Patient denies previous surgeries, recent travel and antibiotic use. Pale female, NAD. Afebrile, 108/70, 81, 18. Abdomen: Soft, bowel sounds present, active, mild LLQ tenderness, no masses, negative guarding or rebound. Rectal: guaiac positive. WBC 3.1, hemoglobin 9.6 hematocrit 29.8, platelets 290, normal differential. CT scan with oral and IV contrast revealed a target pattern and intraluminal soft tissue mass consistent with colo-colonic intussusception. Intussusception occurs when one loop of bowel telescopes into an adjacent segment. Colo-colonic intussusception is a rare cause of intestinal obstruction in adults and is

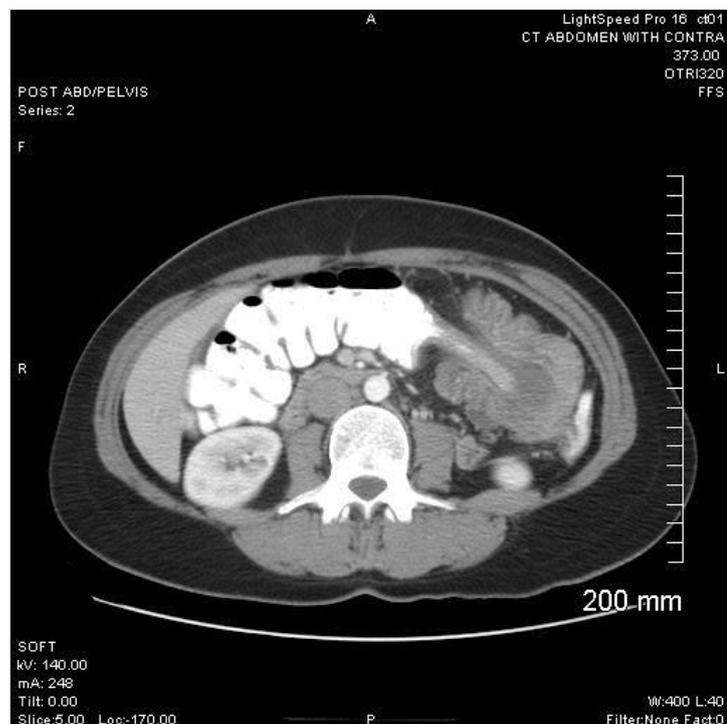


Figure 1: Target pattern and intraluminal soft tissue mass on CT.

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usually associated with a lead point [1,2]. The lead point is most commonly a malignancy, with adenocarcinoma being the most common. It can be benign, however, with lipoma as the most common non-malignant cause. Children usually present with acute onset of colicky abdominal pain and bloody stool, however adults typically have a history of chronic intermittent crampy abdominal pain and bloody stools are less frequent. Adults most commonly present in the 5th or 6th decade. Diagnosis can be reached via CT, colonoscopy, or barium enema, however, CT is the modality most likely to reveal the underlying etiology [3,4]. Non-operative treatments may be successful acutely, however, surgical intervention is the only treatment that removes the underlying cause, thereby virtually eliminating risk of recurrence [1,5] (Figures 1 and 2).

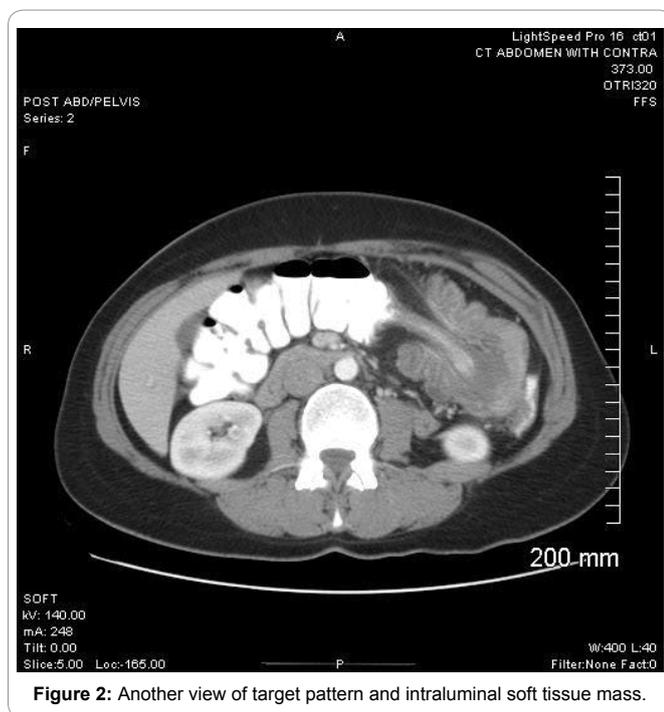


Figure 2: Another view of target pattern and intraluminal soft tissue mass.

Take Home Points

1. Colo-colic intussusception in adults is usually secondary to malignancy. Lipoma's are the most common benign cause, while adenocarcinomas are the most common malignant neoplasm associated with colonic intussusception [6].
2. Mean age for adult intussusception is typically in the 5th or 6th decade of life
3. This case highlights a rare case of large bowel obstruction in a young patient
4. Treatment includes primary resection without attempts at reduction

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