

# Adult Ileocolic Intussusception Due to an Intestinal Lipoma

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## ABSTRACT

Intussusception is a disease of childhood and almost always the etiology is idiopathic. We report the case of an 85-year-old woman with ileocolic intussusception that was diagnosed by abdominal computed tomography. With the symptoms of abdominal pain, distention, nausea and vomiting, she subsequently underwent emergency right hemicolectomy. The final diagnosis was ileocolic intussusception due to lipoma, which was confirmed by histopathology. In elderly, frequent diarrhea attacks, colicky pain and incomplete obstruction should be taken into consideration as a possible diagnosis in this uncommon clinical condition.

**Key words:** Intestinal obstruction, ileocolic intussusception, intestinal lipoma

## İNTESTİNAL LİPOMA BAĞLI ERİŞKİN İLEOKOLİK İNTUSUSEPSİYONU

### ÖZET

İntususepsiyon özellikle çocukluk çağının, etiyolojisi her zaman belli olmayan bir hastalıktır. Biz 85 yaşında tomografik incelemede ileokolik intususepsiyon tanısı alan bir olguyu sunuyoruz. Karın ağrısı, distansiyon, bulantı ve kusma şikayetiyle başvuran hasta acil operasyona alınarak sağ hemikolektomi uygulanmıştır. Histopatolojik inceleme sonucunda lipoma bağlı ileokolik intususepsiyon tanısı konmuştur. Özellikle yaşlılarda sık diyare atakları, kolik ağrıları, tam olmayan tıkanıklık durumlarında bu nadir klinik tablo hesaba katılmalıdır.

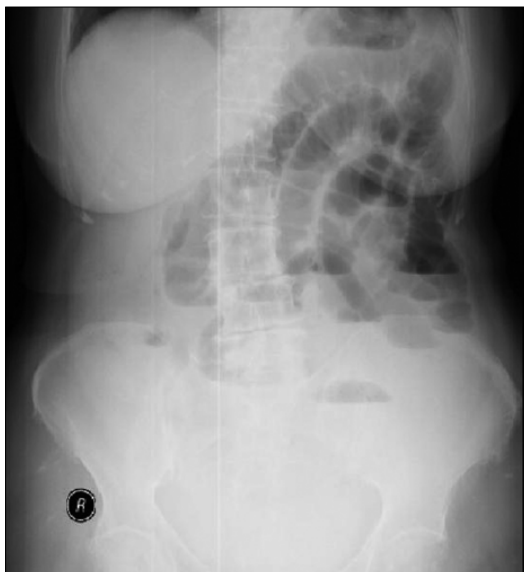
**Anahtar sözcükler:** Bağırsak tıkanıklığı, ileokolik intususepsiyon, intestinal lipom.

Intussusception is a disease of childhood and almost always the etiology is idiopathic. It is seen in 1/30.000 of all hospital admissions and 1/3.000 of all abdominal operations (1). The rare form seen in adults is usually due to a lead point and might be difficult to diagnose.

## Case report

An 85-year-old woman presented to the emergency department with abdominal pain, distention, nausea and vomiting. She had diarrhea with 2-3 loose stools for three days. Stool examinations had revealed no infectious, amebic or parasitological etiology. She had no defecation for the last 3 days. Her distention was apparent and abdominal pain was crampy and intermittent especially for the last two days. On physical exam, she had increased bowel sounds, severe tenderness and rebound tenderness in both

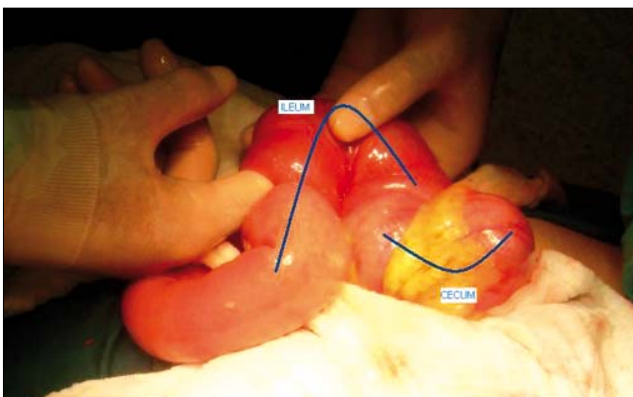
lower quadrants. A palpable mass of 8-10 cm was present in the right lower quadrant. She had no chronic illnesses and no previous history of abdominal operation. Her laboratory results showed a WBC of 15,000 /mm<sup>3</sup>; the rest of the tests were in the normal ranges. Upright abdominal X-ray demonstrated a small bowel obstruction with multiple air-fluid levels (Figure 1). Ultrasonography revealed intestinal dilatations, loose peristalsis, and intraabdominal minimal free fluid. Abdominal computed tomography (CT) demonstrated ileocolic intussusception with segmental intestinal wall necrosis (Figure 2). Laparotomy revealed an irreducible obstructive ileocolic intussusception and a right hemicolectomy was performed (Figure 3). Histopathology revealed ileocolic intussusception due to an ileal 2 cm lipoma in a distance of 15 cm to ileocecal valve and segmental intestinal wall necrosis of the invaginated ileum (Figure 4). She was discharged without any complications on the fifth postoperative day.



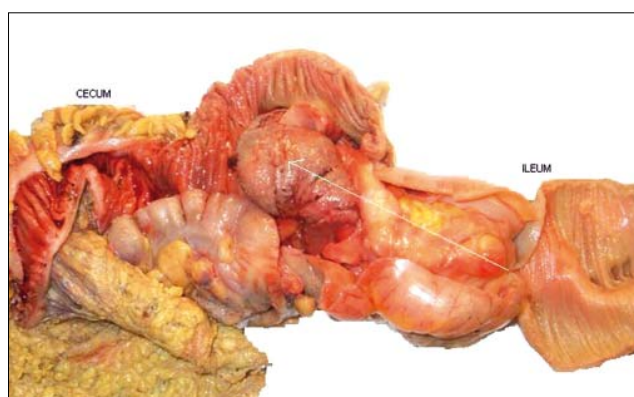
**Figure 1.** Upright Abdominal X-Ray graphy; air-fluid levels in small intestines.



**Figure 2.** Abdominal computed tomography (CT) demonstrating dilatation of small intestines, ileocolic intussusception (target sign) due to an ileal soft tissue tumor of 2 cm with suspicion of segmental intestinal wall necrosis of the invaginated part (Figure 2).



**Figure 3.** Intraoperative view of ileocolic intussusception.



**Figure 4.** Exploration of pathologic specimen; arrow shows invaginated part.

## Discussion

Five percent of all intussusceptions is seen in adults, most frequently involving small bowel (64%), and in 80- 90% of cases a lead point is demonstrated as an etiologic reason which is usually a lipoma, leiomyoma, lymphoid hyperplasia or trauma (2,3). Malignant lesions comprise 14% and 58% of small bowel and colonic intussusceptions, respectively. Metastatic melanoma is the most frequent malignant lesion causing small bowel intussusception. Colonic intussusception occurs more frequently secondary to malignant lesions, with adenocarcinoma and lymphoma being the most common (1-5).

Chronic intermittent abdominal pain is the most frequent symptom in adults. Nausea, vomiting, and stool containing mucus are other symptoms. Acute abdomen

due to intussusception is rarely seen among adults in contrast to children. Upright X-ray, ultrasonography, computed tomography, double contrast upper and/or lower gastrointestinal series and colonoscopy are important diagnostic tools. Target, dough nut or pseudokidney signs are pathognomonic sonographic findings whereas the characteristic tomographic features include an early target mass with enveloped, eccentrically located areas of low density and venous congestion of intussuscepticum (5-8).

Hydrostatic reduction with barium or contrast medium might be the first choice for treatment of intussusception in children; however, due to the usual presence of a leading mass lesion and malignant potential of it, segmental en-bloc resection is preferred in adults. Laparoscopic or open access might be selected (1,5,8-10).

Since the symptoms of intussusceptions in adults is usually nonspecific, it is difficult to diagnose before it causes acute abdomen. Incomplete obstruction, mucoid diarrhea, and colicky pain may remind us of

intestinal intussusception before it is complicated. A high index of suspicion, in addition to ultrasonography and especially CT may be very helpful for the diagnosis.

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