

Ileocaecal Intussusception on a Lipoma-A Case Report

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ABSTRACT

Contrary to the primitive forms of the infant Acute intestinal intussusception is a rare entity in children. Adult, showing 10% of all intussusceptions and 4% of intestinal obstructions in adults. And an organic lesion is often found at the point of weakness of the intussusception in 80% of the cases at the adult. Malignant tumors represent the first etiology of intussusceptions, especially in the colon, whereas they are secondary to a benign lesion (especially in the hail) in 25% of cases. Treatment is always surgical in adults and leaves no room for reduction by hyperpressure under radiological control.

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Introduction

Case report

This is a 45-year-old man who consulted urgently for paroxysmal acute painful crises without triggering factors, aggravated for two weeks. Furthermore, there is no gastrointestinal bleeding or fever. The physical examination showed a slightly distended, supple abdomen, with a palpable mass in the right iliac fossa, an emergency ultrasound was performed which showed ileocecal intussusception, The abdominal CT scan confirmed the diagnosis of ileocecal intussusception on a lipoma (figure). The decision to operate was made and the patient was operated on with good progress.

Discussion

Acute intestinal intussusception (AII) corresponds to the penetration of an intestinal segment into the underlying segment, by reversal like a glove finger (intussusception pudding), unlike children, it is a rare entity in children. adult, showing 10% of all intussusceptions and 4% of intestinal obstructions in adults. [1]

The first intussusception was described by Barbette of Amsterdam in 1674 and Sir Jonathan Hutchinson who performed the first intussusception surgery in 1871. [2]

The anatomical forms of intestinal intussusception are multiple but the ileo-colic form remains the most frequent, colo-colic, colorectal, colo-anal or jejuno-gastric intussusceptions are rare units. [2,3]

The circumstances of discoveries are very varied with an often chronic evolutionary mode making the diagnosis sometimes difficult. The evolution of the intussusception is chronic with intermittent abdominal pain associated with sub-occlusive attacks. [4,3]

Contrary to the primitive forms of the infant, an organic lesion is often found at the point of weakness of the intussusception in 80% of the cases at the adult. Malignant tumors represent the first etiology of intussusceptions,

especially in the colon, whereas they are secondary to a benign lesion (especially in the hail) in 25% of cases. [5]

Organic lesions are essentially represented by stromal tumors, lipomas, polyps, adenopathies, adenocarcinoma and metastases.

The diagnosis is mainly based on imaging:

ASP of little interest can mount the head of the pudding as an air-molded water tone mass of the downstream intestinal segment is very rare.

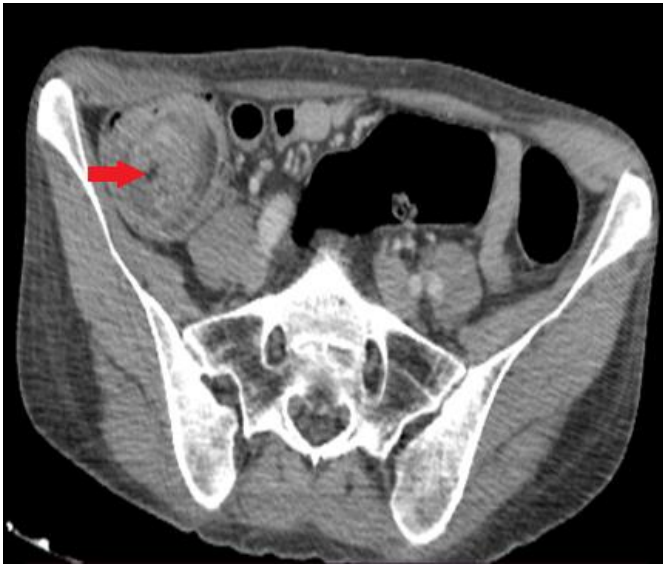
On ultrasound, the invagination presents an external hypoechoic annular band which corresponds to the wall of the edematous invaginating loop. The hyperechoic invaginated mesentery in the center or slightly eccentric surrounded by echogenic hypo-iso folds of the invaginated loop. In transverse section, the intussusception appears in the form of the classic target image composed of a hypoechoic external annular band representing the receptive loop and a central echogenic-hyperechoic zone associating the loop and the invaginated mesentery. The pseudo-kidney image appears on the longitudinal section. [5, 6,7]

On CT, the typical Target-like image consists of a thickened hyperdense outer segment (intussusception) circumscribing an eccentric hypo or hyperdense ring depending on the underlying cause and a stratified tissue ring with hypodense or slightly hyperdense serous edema corresponding to the edematous walls of the invaginated loop[8]

Treatment is always surgical in adults and leaves no room for reduction by hyperpressure under radiological control. [9]

Conclusion

Acute intestinal intussusception is a rare entity in adults, the ileocolic form remains the most frequent, an organic lesion is often found dominated by stromal tumors, lipomas, polyps, and lymphadenopathy, The radiological diagnosis is based on the ultrasound/CT pair, treatment is always surgical in adults.



Abdominal CT : ileo-caecal intussusception presenting a stratified appearance with individualization of an intra-caecal lesion of fatty density related to a cecal lipoma (arrow).

⇒ Appearance compatible with ileocaecal intussusception on lipoma.

Reference

1. Lebeau R, Koffi E, Diané B, Kouassi JC. Invaginations intestinales aiguës de l'adulte : analyse d'une série de 20 cas. *Ann Chir.* 2006;131(8):447–50.
2. De Moulin D, Paul Barbette MD. A seventeenth-century Amsterdam author of best-selling textbooks. *Bull Hist Med.* 1985; 59(4):506–14.
3. Boubbou M, Idrissi M, Chraib M, Ibn majdoub K, et al. Invagination intestinale aigüe chez l'adulte. *Feuillets de Radiologie.* 2009;49(2):99–104.
4. Kamaoui I, Bouhouch F, Boubbou M, Tizniti S. Invagination grêlo- grêlique chez l'adulte secondaire à un lipome. *Feuillets de Radiologie.* 2007;47(1):42–5.
5. Haas EM, Etter EL, Ellis S, Taylor TV. Adult intussusception. *Am J Surg.* 2003; 186(1): 75–6.
6. Michael A, Dourakis S, Papanikolaou I. Ileocaecal intussusception in an adult caused by a lipoma of the terminal ileum. *Ann Gastroenterol.* 2001;14(1):56–9.
7. Sirinelli D, Guilley C, Boscq M. Invagination intestinale aiguë: la désinvagination, quand et comment? *J Radiol.* 2003; 84(3):269–74.
8. Fujii Y, Taniguchi N, Itoh K. Intussusception induced by villous tumor of the colon: sonographic findings. *J Clin Ultrasound.* 2002; 30(1):48–51.
9. Bar-Ziv J, Solomon A. Computed tomography in adult intussusception. *Gastrointest Radiol.* 1999;16(3):264–6.
10. Lvoff N, Warren RS. Distinguishing features of self-limiting adult small bowel intussusception identified in CT. *Radiology.* 2003; 227(1):68–72.
11. Just PA, Hoang C, Cadi M, Capron F. Invagination intestinale aiguë de cause inhabituelle. *Gastroenterol Clin Biol.* 2005; 29(11):1160–3.
12. Zeebregts CJ, Prevo RL, Klaase JM. Jejunojejunal intussusception secondary to adenocarcinoma. *Am J Surg.* 2004; 187(3): 450–1.