

Introduction

- It often occurs in areas where a proximal mobile region is adjacent to a distal fixed region.¹
- Incidence of adult intussusception has increased from 5% to as much as 23% of all intussusception diagnoses.^{2,3}
- Ileocolic intussusception comprises less than 5% of adult intussusceptions.⁴
- Adult intussusception is rarely idiopathic with over 70% of cases caused by tumors and polyps.⁵
- Approximately 50% of lead point lesions in adult patients are malignant.⁵
- Adults often present with vague symptoms, such as chronic abdominal pain, nausea, and vomiting, rather than the classic triad of abdominal pain, palpable mass, and currant jelly stool.^{4,6-8}
- Contrast-enhanced computed tomography (CT) scans are the preferred diagnostic modality, with characteristics such as a reniform-pattern, shorter length, larger diameter, hyperdense appearance, and non-round or oval shaped masses indicative of malignant lead points.^{5,9}
- Complications, such as ischemia, necrosis, perforation, edema, or hemorrhage, may arise if untreated.¹⁰

Case Description

History

- 62 -year-old male complaining of periumbilical abdominal pain and anorexia for the past month with a 12lb weight loss over the past 2 weeks. He endorses worsening with food intake.
- Past medical history: hypertension, chronic kidney disease, iron deficiency anemia, chronic alcohol use
- Medications: amlodipine 10 mg PO daily, losartan 100 mg PO daily, metoprolol tartrate 25 mg PO BID
- NKDA
- No past surgical history
- Family History: Pancreatic cancer (father)
- Social History: tobacco and marijuana use, 8-9 alcoholic beverages daily
- Review of Systems: Denies fever, chills, chest pain, shortness of breath, nausea, vomiting, hematochezia, constipation, diarrhea, back pain, dysuria, hematuria, or adenopathy

Differential Diagnosis included in Table 1

Physical Exam

- Vitals:
 - BP 162/91 mmHg
 - HR 61 bpm
 - RR 18 br/min
 - T 37.1 °C
 - SpO₂ 100% on room air
- General: AOx4, well-appearing, no acute distress
- Cardiac: regular rate and rhythm, S1 and S2 appreciated without murmurs, rubs, or gallops, 2+ radial and dorsalis pedis pulses bilaterally
- Pulmonary: symmetrical chest expansion, non-labored vesicular lung sounds bilaterally without adventitious lung sounds
- GI: atraumatic and flat, soft, non-distended, nontender to palpation in all 4 quadrants, no masses appreciated
- GU: no costovertebral angle tenderness

Diagnostic Results

- Laboratory Analysis: Hgb 11.9 g/dL, Hct 37.4%, Cr 1.24 mg/dL, HCO₃ 19 mmol/L, Lactic acid 2.1 mmol/L, ALT 9 U/L
- Urinalysis: trace proteins and ketones
- Abdominal CT: “Ileocolic intussusception with a 3.4 x 3.6 cm enhancing lesion at the leading edge of the intussusceptum”
- Figure 1 shows results of abdominal CT scan.
- Figure 2 shows the histopathology of the ileal mass.

Discussion

Case Outcomes

- Segmental distal ileal resection was performed.
- Final diagnosis of ileal mass was a well-differentiated neuroendocrine tumor G1.
- Patient had an uncomplicated recovery and was discharged on postoperative day 3.
- Patient transitioned to outpatient care for continued follow up and management.

Recommended Treatment for Adult Intussusception

- Due to the high rate of neoplastic causes, surgical resection of the affected region remains the mainstay of treatment.^{1,4-7}
- Decompression increases the potential for further spread of malignancy but may be used in some cases to reduce the length of unaffected bowel resected.^{4,7}

Conclusion

- Intussusception is rare among adults and often has a vague presentation.
- Lead points are often pathological in adults.
- A CT scan is the preferred diagnostic tool and can display characteristics of malignancy.
- Surgical resection remains the mainstay of treatment.

References

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Table 1. Differential Diagnosis

Gallstone Ileus	Cholecystitis
Colorectal Carcinoma	Appendicitis
Ventral Hernia	Cecal Volvulus
Crohn's Disease	Lymphadenopathy
Lymphoma	Functional obstruction

Fig 1. Coronal and Axial Abdominal CT Scan

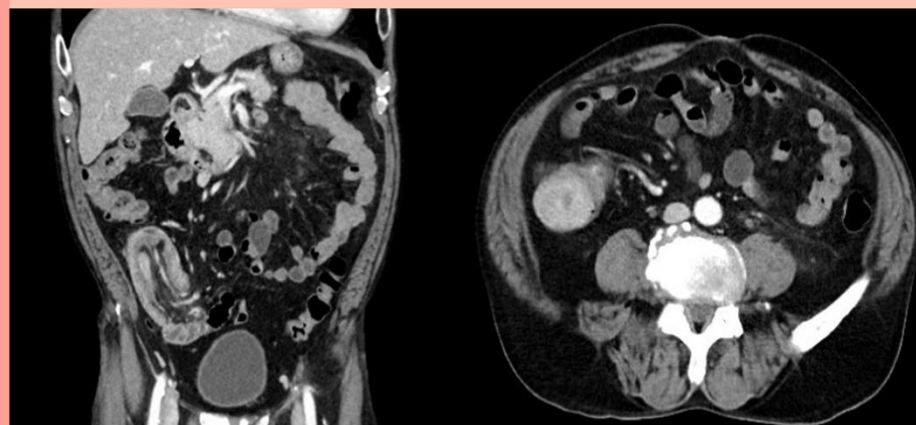


Fig 2. Histopathology of Ileal Mass Biopsy

