

## **Case Report**

# **A Rare Case of Gangrenous Jejunoileal Intussusception Secondary to Jejunal Polyp**

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**Abstract:** Gangrenous intussusception is a life threatening condition requiring urgent resuscitation, early exploration and resection of the affected bowel to reduce mortality and morbidity. Jejunal polyps causing such pathology are rare and unique. Here we present one such case.

**Keywords:** Intussusception, Jejunal Polyp, Intestinal Obstruction.

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## **INTRODUCTION**

Intussusception is a common cause of paediatric acute abdomen however the incidence of adult intussusception is about 2 - 5% of all cases of intussusceptions [1]. Children often have a classical presentation of acute onset, episodic abdominal pain, currant jelly stools, and vomiting. Adults with chronic intussusception often present with a vague history of symptoms that might include diarrhoea, constipation, and weight loss. Nausea, vomiting, and abdominal pain are the most common manifestations among adults. An acute presentation of a chronic intussusception is common among adults [2].

## **CASE REPORT**

A 25 year old male patient presented to our Emergency with complaints of pain abdomen and vomiting since three days, constipation and abdominal distension since two days. Patient had similar complaints in the past but the severity of the symptoms were much lesser and often subsided on their own. He experienced such symptoms almost once in two months and each episode lasting for one or two days for the last two years. On examination patient had tachycardia, was dehydrated, and tachypnic. His blood pressure was 90/60 mmHg. Abdominal examination revealed uniform distension of abdomen, guarding and tenderness in all quadrants. Bowel sounds were absent. A per rectal examination revealed a roomy rectum with altered blood. A clinical diagnosis of acute intestinal obstruction with strangulation was made and patient resuscitated. Patient was planned for emergency

laparotomy and routine laboratory profiles were sent. Investigations revealed a leucocytosis of 11600 with a neutrophilia of 92 percent and haemoglobin of 10.0gm. An erect x ray abdomen revealed multiple air fluid levels suggestive of small bowel obstruction. Patient was taken for emergency laparotomy. Abdomen opened with a midline incision centered on the umbilicus. There was evidence of gross intestinal distension. An intussusception was noted 200 cm proximal to the ileocecal valve with about 50 cms of intussusceptions. The bowel was congested oedematous and there were frank gangrenous changes. A resection and anastomosis was performed. On palpation of the rest of the small bowel, an intraluminal pedunculated polyp was felt 20 cms distal to the duodenojejunal flexure. A jejunotomy was performed and the polyp excised and a formal resection anastomosis with 5 cm margins performed. A thorough wash was given, drains placed and abdomen closed in layers. On examination of the resected specimen a sessile polyp was found to be the lead point of intussusception. Both specimens were sent for histopathological examination. The post-operative course of the patient was uneventful and the patient recovered fully. Histopathology revealed that the two polyps measured 3x2x1 cms (isolated pedunculated) and 2.8 x 1.5 x 1 cm (lead point of intussusception), solid homogenous adenomatous polyps with no evidence of nuclear atypia or malignancy.



**Fig. 1: Resected Specimen of gangrenous jejunoileal intussusception**



**Fig. 2: Cut open specimen showing pathological lead point - Jejunal polyp**



**Fig. 3: Concomitant polyp in the proximal jejunum**

## DISCUSSION

Intussusception in adults is a rare cause of abdominal pain found in less than 1% of patients presenting with small bowel obstruction [3]. A pathological lesion in the bowel wall is found in 90%

with two third of the lesions being benign and one third malignant [4]. Benign tumours of the small intestine account for almost 30 – 50 % of primary small bowel neoplasms. Benign tumours are poorly characterized and most of the patients who harbour such tumours are symptom free. Small bowel neoplasms are often diagnosed when they present with obstruction, gastrointestinal haemorrhage or perforation. Obstruction is common with adenomas while gastrointestinal bleeding and perforation are seen with malignant tumours, gastrointestinal stromal tumours and carcinoid tumours.

Our patient had an acute on chronic presentation, the small bowel adenoma revealing itself at emergency laparotomy as a lead point of the intussusception. His past history explains the possibility of recurrent intermittent intussusception which spontaneously reduced. Patient had been treated conservatively in his earlier presentations and multiple ultrasound scans of the abdomen had failed to pick up any lesion. Our case highlights the importance of adult intussusceptions as a rarer cause for recurrent abdominal pain. In the non-acute setting such patients may benefit from investigations such as contrast enhanced computed tomography or small bowel enteroclysis when intussusception is suspected, in order to better delineate possible pathological lead points.

## CONCLUSION

Gangrenous intussusception is a rare cause of acute abdomen in a young adult. Adult intussusceptions have well documented pathological lead points unlike childhood intussusception which occur most frequently to lymphoid hyperplasia. Jejunal adenomatous polyps are benign neoplasms which often go undetected or remain asymptomatic. These act as lead points of intussusception and may be associated with recurrent intermittent intussusception. Most cases are managed by operative reduction alone while gangrenous intussusceptions necessitate resection and anastomosis. Intra-operatively it is prudent to palpate the entire small intestine for recognition of any other concomitant polyps.

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