Case report:

Adenocarcinoma Caecum presenting as ileo- caeco- colic intussusception

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Abstract:

Adult intussusception is a rare condition seen in just 5% of all intussusceptions. We present a case of adult intussusception clinically presenting as a lump in the abdomen. Radiological investigations revealed ileo-caeco- colic intussusception. Patient underwent laparotomy. On histopathology, adenocarcinoma of the caecum was confirmed as the cause.

Key words: Lump in Abdomen, Adult intussusception, Adenocarcinoma Caecum

INTRODUCTION:

Intussusception is telescopic invagination of a proximal segment of the bowel into the adjacent distal segment of the bowel. Most cases present in paediatric age group. Approximately 5% cases present in adults, which is 1% of total cases of intestinal obstruction (1-3). We report a case of adult intussusception due to adenocarcinoma caecum as the lead point.

CASE REPORT:

A 48 year old male patient had complaints of dull aching pain all over abdomen since 1 year. He had no history of chronic cough, evening rise of temperature, passing worms in stools, change in bowel habits, abdominal distension or vomiting. On examination a 5X5 cm, firm, irregular, non- tender lump was palpable in the right iliac fossa. Rest of the abdominal and systemic examination was normal. USG abdomen showed a 4.4X5.4 cm concentric whirled pattern of bowel loops in right iliac fossa region with bowel in bowel pattern in longitudinal section suggestive of ileocaecal intussusception. CT scan of the abdomen showed a long segment ileo-caeco- colic intussusception extending up to hepatic flexure with a suspicious 10 mm diameter fat density lesion at head of intussusception suggestive of lipoma along with 3-4 hypo echoic lymph nodes largest measuring approx 12X8mm.

On exploratory laparotomy, we found an ileo- caeco-colic intussusception which could be reduced manually. Few small nodes were seen in the mesentery. There was an intramural hard mass of size 3X2 cm arising from caecum. Resection of terminal ileum, caecum, appendix and ascending colon with en bloc resection of lymph nodes with ileo-transverse anastomosis was done.

On opening the specimen, a polypoidal lesion was seen in the caecum. Histopathological examination revealed a moderately differentiated adenocarcinoma of the caecum with the tumor extending up to subserosa. Dissected lymph nodes were normal.

Post operative recovery was uneventful. Patient received adjuvant chemotherapy with oral capacetabine.

DISCUSSION:

Intussusception means invagination of a proximal segment of the bowel into the adjacent distal segment of the bowel. First described by Barbette in 1674, it

was known as a disease of infancy and childhood (4). Adult intussusception is very rare constituting approximately only 5% cases. Paediatric intussusception is mostly idiopathic whereas in adults , it is generally secondary to an organic lesion identified as a lead point in 90% cases, malignant in 27–48% of the cases (5,6).

Paediatric intussusception is mostly idiopathic whereas in adults, in 90% of the cases a lead point can be identified. In around 65% of cases the cause is either benign or malignant neoplasm [7, 8]. The incidence of malignant neoplasm is between 50%-71% in cases of colonic intussusceptions [9, 10].

Intussusceptions are classified on the basis of their location as enteric, colonic and ileocaecal or ileocolic (11, 12).

Diagnosis of adult intssusception is difficult as symptoms are non specific (13). Most common presenting complaints are pain in abdomen, nausea, diarrhoea and bleeding per rectum with only 10% of cases having a lump (14). Therefore most of the time patient receives either symptomatic treatment or are treated for other abdominal diseases like gastritis (15). Patient presents with intestinal obstruction when the disease is advanced.

No single laboratory investigation is diagnostic. Serum CEA is a non specific tumor marker, as abnormally high levels are also present in other gastrointestinal cancers (stomach, liver etc.) (16). CT scan of the abdomen is the best diagnostic tool (17).Colonoscopy has been increasingly used to diagnose non-small bowel intussusceptions. (18, 19). On barium enema examination, a locally advanced lesion would appear as a filling defect with destroyed mucosal pattern (12) and it should be investigated with colonoscopy (13). However, Spiral Hydro CT Scan (14) and MRI (15) are helpful in assessing extra mural extension..

In view of uncertain aetiology, varying duration of symptoms and high incidence of malignancy in adults, surgical resection of intussusception without reduction is recommended (2, 16, and 17). However, in benign enteric intussusceptions or when the primary resection involves a significant percentage of the bowel, reduction must be attempted (11). The primary lesion is resected, even if distant metastases have occurred, since prevention of obstruction or bleeding may give long term palliation (15). The role of adjuvant radiation therapy is controversial. Various chemptherapeutic regimens are under trial at present.

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