Surgery Research Journal
ISSN: 2768-0428

Case Report

Acute Intestinal Obstruction by Intussusception at the Communal Medical Center of Ratoma About A Case

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- Received Date: 12 Sep 2023
- Accepted Date: 20 Sep 2023
- Publication Date: 11 Oct 2023

Keywords
Intestinal obstruction, Cessation of matter and gas, Intussusception

Abstract

Acute intestinal obstruction by intussusception is defined by a cessation of materials and gases due to the penetration of an intestinal segment into the segment immediately adjacent to it . We report a case of intussusception concerning a 26 year old lady, admitted to the General Surgery department of the Ratoma Communal Hospital for acute intestinal obstruction, in whom an unprepared abdominal X-ray was performed which revealed central hydroaeric levels multiple steps and a biological assessment before being taken to the operating room. Intraoperatively, inflammatory fluid leaked and exploration revealed catarrhal appendicitis and an ileo-ileal intussusception located 6 cm from the ileocecal angle, the disinvagination of which revealed a thickening of the wall of the invaginated loop and a mass of approximately 1 cm. We performed a resection of the invaginated loop followed by reestablishment of end to end ileo-ileal digestive continuity and an appendectomy. The postoperative course was simple.

Introduction

Acute intestinal intussusception in adults is defined as the penetration of a segment of intestine into the underlying segment, like an upturned thimble, in a person with age greater than or equal to 15 years, causing intestinal obstruction [1]. It is rare in adults and represents only 1% of intestinal obstructions. In adults, an organic cause is found in 70% to 90%, with notably 65% having a neoplastic cause [2]. Intussusception in adults contrasts with intussusception in children in its clinical, etiological, therapeutic and prognostic aspects [3]. Preoperative diagnosis is difficult and treatment is surgical.

The aim of this work was to report a case of intestinal obstruction due to intussusception in our department.

Observation

TThis is a 26-year-old lady, admitted for abdominal pain, vomiting, cessation of matter and gas and rectal bleeding. History of external hemorrhoid. Patient seen conscious, anxious, cooperative, active attitude, hypo-colored integument and conjunctiva presenting a satisfactory general condition with the following parameters: BP: 130/70mmhg, pulse: 72 pulses/min, temperature: 37.1°C and FR: 24 cycles/min. On physical examination, distended abdomen with little participation in breathing, without surgical scar, elastic resistance was noted; diffuse tympanism, preserved pre-hepatic dullness, no sloping dullness of the flanks, audible intestinal peristalsis. The vaginal examination did not reveal any particularity, the rectal examination: we noted a hemorrhoidal rim at 3 o'clock, the tonic sphincter, the empty rectal bulb, the Douglas fir neither bulging nor painful; the finger cot came out clean. The examination extended to other devices did not reveal any particularity. An X-ray of the abdomen without preparation was carried out which revealed hydroaeric levels wider than high, central, multiple in a staircase and a preoperative biological assessment whose particularity was a THB: 10g/dl before be admitted to the operating room. Intraoperatively, inflammatory fluid leaked which we aspirated and estimated at 150 cc, the exploration revealed catarrhal appendicitis and an ileo-ileal intussusception located 6 cm from the ileo-caecal junction, including the disinvagination allowed us to see a thickening of the wall of the invaginated loop and a mass approximately 1 cm in diameter. We carried out a resection of the invaginated loop in a supposedly healthy area followed by reestablishment of digestive continuity by an end-to-end ileo-ileal anastomosis, an appendectomy plus parietal closure plane by plane on a drain in the Douglas fir and dressing. The immediate postoperative course

Citation: Camara SK, Diallo MA, Guirassy MII, Bah TS, Keita DM, Diawara MA. Acute Intestinal Obstruction by Intussusception at the Communal Medical Center of Ratoma About A Case. Surg Res J. 2024;4(1):1-3

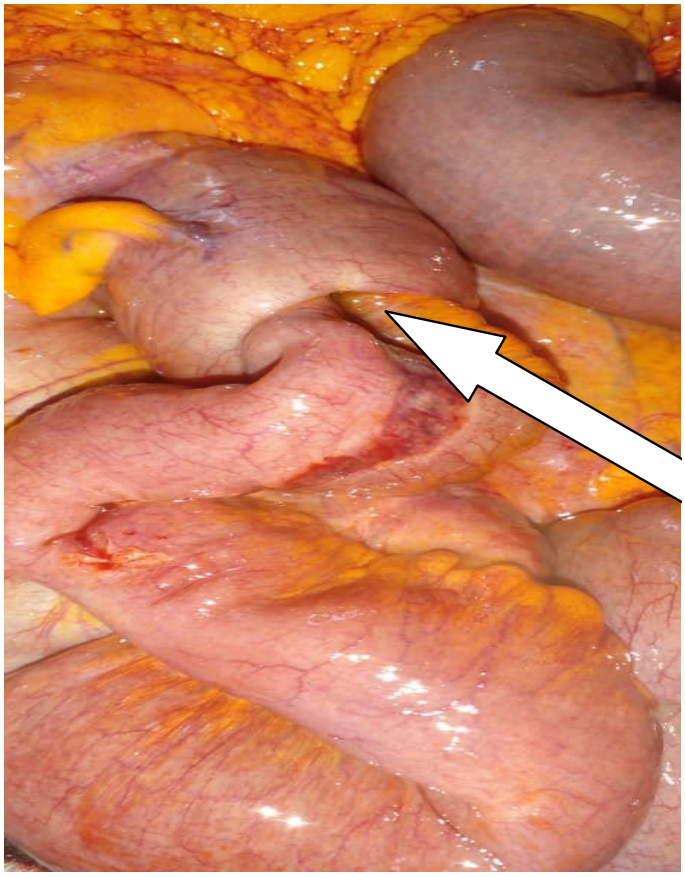

Figure 1: Investigation

was simple, and the patient received ceftriaxone 1g every 12 hours, infusionable paracetamol 1g as needed and injectable hemafer for seven days. The patient was released on her 9th postoperative day with an improvement in her state of health.

Discussion

Acute intestinal intussusception in adults is a rare pathology, representing 1% of obstructions in Europe and 3% in Africa, often of organic cause. These organic causes can be benign or malignant tumors, the intestinal location of which is the most common and often the site of benign lesions (lipomas and adenomatous or fibro-inflammatory polyps), unlike the colonic site, where most often these are causes malignant (lymphomas, adenocarcinomas, carcinoids, leiomyosarcomas or metastases) [4]. Several authors have reported that this condition is common in young adults aged between 33 and 44 years. The sex ratio is 1, i.e. as many men as women [5]. The symptomatology is dominated by a picture of acute intestinal obstruction in 10 to 30% of forms in Europe compared to 75-100% of cases in Africa [4]. This symptomatology is polymorphous and most often misleading resulting in an acute or sub-occlusive occlusive syndrome which can last from a few days to a few weeks or even by non-specific abdominal syndromes (stopped transit, diffuse abdominal pain, vomiting, digestive bleeding), sometimes evolving for several months, with or without alteration of general condition [6,7]. Furthermore, the clinical picture may manifest as a peritoneal syndrome secondary to perforation or which may simulate appendicitis [4]. In our case the clinical signs were dominated by abdominal pain, cessation of materials and gases and rectal bleeding. CT is the examination of choice, reliable in 58% to 100% of cases for confirmation of the diagnosis of intussusceptions in adults, particularly in mildly symptomatic patients; it makes it possible to define the location, the nature and sometimes the cause [8,9]. Abdominal ultrasound has been the reference examination for several years, it highlights intestinal intussusception in 60% of cases, limited by the abundance of gas due to intestinal obstruction and it is operator-dependent. . As for the X-ray of the ASP, it is only important in the diagnosis of complicated forms (occlusion or peritonitis) [10]. In our patient, only the ASP was performed, which revealed central hydroaeric levels, multiple in steps, and the diagnosis was made intraoperatively. Surgery remains the best treatment for intussusception in adults; it aims to treat the occlusion but also to cure the cause if possible. Resection is justified in cases of necrosis of the sausage and/or in cases of tumor, and disintussusception is not recommended by the majority of authors in cases of signs of intestinal distress or in the absence of formal preoperative proof of benignity of the causal lesion [4,11]. Given the thickening of the wall of the invaginated loop and the presence of a mass of approximately 1cm in diameter in our patient, we carried out a resection of the invaginated loop followed by restoration of the digestive continuity through an end-to-end ileo-ileal anastomosis.

Conclusion

Acute intussusception is a rare pathology in adults whose etiology is often tumoral; the diagnosis is generally made intraoperatively. The treatment is always surgical and takes into account the causal lesion. Hence, the prognosis of this condition is mainly linked to the precocity of the management because of the clinical presentations but also the stage of evolution of the lesion.

Conflict of interests

The authors report no conflicts of interest.

Author contributions

All authors contributed to the conduct of this work. They also declare that they have read and approved the final version of the manuscript.

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