

Intussuscepted sigmoid adenocarcinoma diagnosed via endoscopic ultrasonography

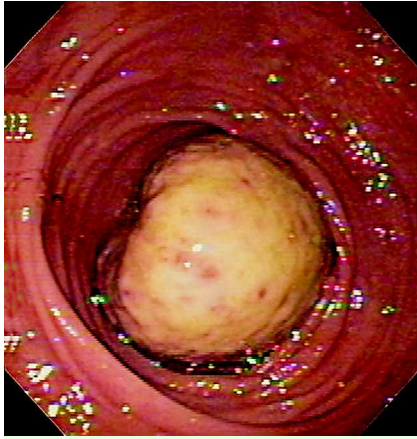


Fig. 1 Endoscopic image of colonic intussusception.

Intussusceptions are rare occurrences in which a proximal bowel segment invaginates into the distal lumen. Usually neoplastic, a lead point can be identified in 70–90% of cases by either abdominopelvic CT (CTAP) or transabdominal ultrasonography [1]. We describe the use of en-

doscopic ultrasound to identify a malignant lead point in a colonic intussusception.

A 71-year-old gentleman presented to the Ann Arbor Veterans Hospital with a 4-month history of intermittent abdominal pain, constipation, and hematochezia. He had no family history of colorectal cancer or inflammatory bowel disease. His rectal examination was significant for gross blood and a large palpable mass. Colonoscopy revealed a tubular mass that started 3 cm from the anal verge and obstructed 90% of the lumen (▶ **Fig. 1**). Multiple biopsies were unrevealing. CTAP revealed changes consistent with sigmoid intussusception, but no distinct mass or lead point could be identified (▶ **Fig. 2**). Subsequently, rectal endoscopic ultrasonography (EUS) revealed a hypoechoic mass measuring 1.1×1.7 cm in the apex of an intussusception (▶ **Fig. 3**) without perirectal lymphadenopathy. The patient underwent partial sigmoidectomy. Histopathology revealed a moderately differentiated T2N0M0 adenocarcinoma.

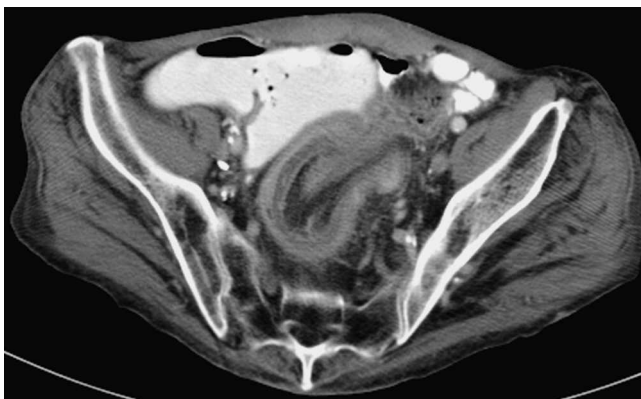


Fig. 2 Abdominopelvic CT image of sigmoid intussusception.

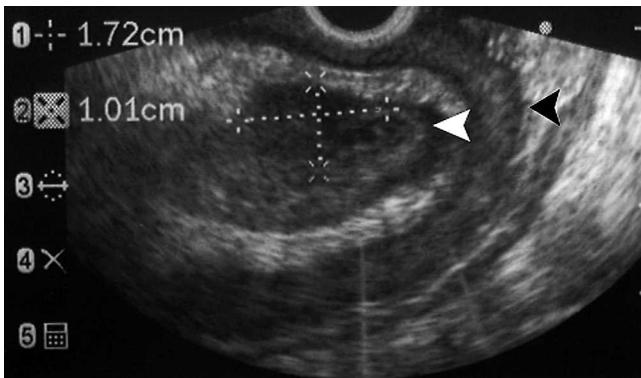


Fig. 3 Endoscopic ultrasound image of sigmoid intussusception (black arrow) with adenocarcinoma at the apex of the intussusception acting as the lead point (white arrow).

In adults, intussusceptions represent less than 5% of all intestinal obstructions [1]. However, malignancies account for more than 50% of colonic intussusceptions [2–4]. Unlike in pediatric cases, barium hydrostatic reduction is not commonly performed in adults, because of increased risks of perforation or malignant dissemination [2,5]. For our patient, mechanical reduction was considered since his initial imaging was negative. However, given the high pretest probability of an underlying malignancy, preoperative EUS was performed to guide surgical therapy. This case depicts the ability of EUS to identify malignancies within intussuscepted bowel that were missed on cross-sectional imaging. EUS can therefore be considered as an alternative modality for the evaluation of a rectosigmoid intussusception.

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Bibliography

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