

Case Report

An Uncommon Presentation of an Uncommon Colonic Neoplasia

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ABSTRACT

Intussusception in adult is a rare clinical entity. The clinical presentation of adult intussusception is often nonspecific. Majority of the cases have been reported as chronic, consistent with partial obstruction. We report a case of a 53-year-old male, who presented with chronic diarrhea and vague abdominal discomfort. He was incidentally detected to have colocolic intussusception secondary to colonic lipoma during diagnostic colonoscopy.

KEYWORDS: Contrast-enhanced computed tomography, human immunodeficiency virus, IgA tissue transglutaminase

INTRODUCTION

Adult intussusception is rare and represents only about 5% of all intussusception with variable clinical presentation.^[1] The classic triad of crampy abdominal pain, bloody (“currant jelly”) stool and a palpable mass of acute intussusception as pediatric presentation is rare. Colonic lipomas are rare submucosal benign tumor. Colonic lipomas are usually asymptomatic, but lipomas >2 cm can rarely present with intussusception.

CASE REPORT

A 53-year-old male with no previous comorbidities, presented with 2-month history of increased stool frequency and occasional mild abdominal discomfort. Patient stool frequency was 3–4/day. Stool was liquid to semisolid in consistency, small volume, and easy to flush. No history of hematochezia, melena, fever, loss of weight, loss of appetite, nocturnal awakening, and incontinence. There was a history of occasional, mild, self-limiting abdominal discomfort. There was no history of constipation, obstipation, or vomiting. His physical examination was within normal limits. He was given 3-day course of ofloxacin 200 mg and ornidazole 500 mg twice daily for 3 days in an outside medical facility. He had no relief in symptoms with above medication. He was evaluated in our clinic for chronic diarrhea. His investigations revealed hemoglobin of 14.6 g% with normocytic normochromic red blood cells, normal leukocyte and platelet count, and normal renal and liver biochemistry. His thyroid function test and serum IgA tissue transglutaminase titer were within

normal limit. He was nonreactive for HIV ELISA. Stool routine microscopy did not show any parasite and pus cells on consecutive three stool samples. Colonoscopy was performed to rule out suspicion of microscopic or Crohn’s colitis. Colonoscopy revealed a large polypoidal smooth surfaced rounded lesion at splenic flexure with severe narrowing of lumen [Figure 1a and b]. Scope was not negotiable across. Biopsy was taken from the head of polypoid lesion and also from rectosigmoid. Histopathological examination from polypoid lesion was suggestive of lipoma, whereas histopathological examination of the biopsy from rectosigmoid was normal. Possibility of intussusception was kept and abdominal Contrast-enhanced computed tomography (CECT) performed. CECT Abdomen revealed 3.8 cm × 2.8 cm sized well-defined fat density lesion within the lumen of splenic flexure of colon, with resultant colocolic intussusception without any suggestion of obstruction [Figure 2a and b]. Hence, diagnosis of colocolic intussusception with colonic lipoma as lead point was made.

Patient underwent open surgery, which confirmed the diagnosis of colocolic intussusception with large lipoma as lead point. Resection of involved segment of colon along with primary anastomosis was done. Histological examination of resected specimen confirmed

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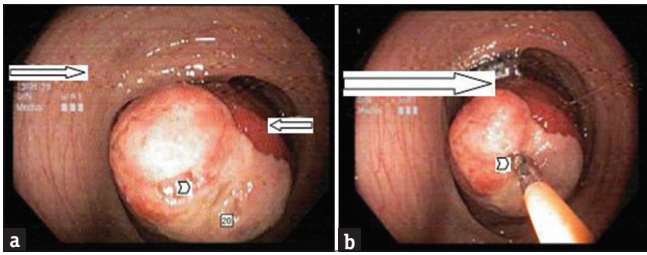


Figure 1: (a) Large white arrow showing intussusciens, small white arrow showing intussusceptum, arrowhead showing lead point lipoma. (b) Transition between the lead point lipoma and intussuscepted colonic segment, arrowhead showing biopsy being taken from lead point

lipoma. Patient was discharged after 5 days and was symptom free.

DISCUSSION

Intussusception occurs when one segment of the gastrointestinal tract (intussusceptum) telescopes into the lumen of an adjacent distal segment of the gastrointestinal tract (intussusciens). Adult intussusception is a rare clinical entity and represents only about 5% of all intussusception.^[1] It is the cause of 1%–3% of all cases of intestinal obstructions.^[2] The mean age at diagnosis is 54.4 years, and the male-to-female ratio is 1:1.3.^[3]

Adult intussusception presenting symptoms are often nonspecific and chronic, consistent with partial obstruction.^[3] Abdominal pain and distension, nausea, vomiting, gastrointestinal bleeding, constipation, and changes in bowel habits are common presenting symptoms.^[4] Fever, weight loss, constipation, and diarrhea are infrequent. A palpable abdominal mass is present in <10% of the patients. Bloody stool is seen only in one-quarter of the patient.^[3] Dance’s sign (apparent right iliac fossa “emptiness”) is only occasionally appreciable.

The clinical features also have an association with the underlying pathological lesion’s nature and site and the presence or absence of a lead point.^[3] The mean duration of symptoms is longer in benign as compared with malignant lesions and in enteric as compared with colonic lesions.

According to location, intussusception classified into four types including ileocolic, ileo-ileo-colic, colocolic, and small bowel intussusception (jejuno-jejunal and ileo-ileal).^[5] In adults, often there is an underlying trigger or nidus for the intussusception in around 90%–95% of the cases.^[6] The majority of lead points in the small intestine consist of benign lesions, whereas in large bowel, majority consist of malignant lesion.^[7]

Colonic lipomas are rare submucosal benign tumor and are usually asymptomatic. Most cases are found incidentally during colonoscopy, surgery, or

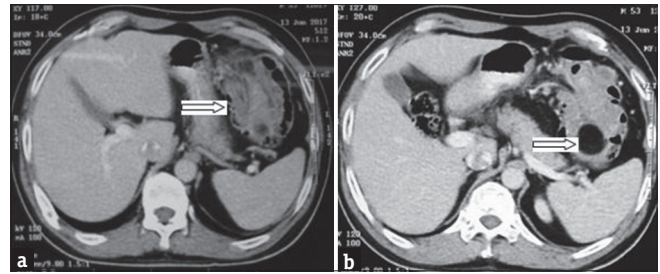


Figure 2: (a) sausage shaped mass with layering effect suggestive of colo-colic intussusceptions at proximal splenic flexure. (b) 3.8 cm × 2.8 cm sized fat density lesion within lumen of splenic flexure of colon acting as lead point for intussusception

autopsy.^[8] Signs and symptoms are generally related with lipomas >2 cm and include abdominal pain, constipation, rectal hemorrhage, and rarely intussusception.^[8] Lipoma of the colon is predominantly localized in ascending colon (61% from the reported cases), followed by descending colon (20.1%), transverse colon (15.5%), and in the rectum (3.4%). Considering that lipomas are most often located in the ascending colon, we present a rare case of a colonic lipoma of the left colon leading to colocolic intussusception.

Abdominal CT is the most useful diagnostic tool not only for detecting an intussusception with a diagnostic yield of around 78% but also helps in identifying the underlying cause.^[9] The characteristic features include a heterogeneous “target” or “sausage-shaped” soft tissue mass with a layering effect. Mesenteric vessels within the bowel lumen are also typical. Plain abdominal X-rays and ultrasound are of limited diagnostic value in adults.

Colonoscopy is valuable not only for confirmation of the intussusception but also help in its localization, demonstration of the underlying organic lesion serving as a lead point, and possible treatment. Endoscopic findings that are characteristic of lipoma are “cushion sign” (forcing the forceps against the lesion results in depression and then restoration of the mass) and “naked fat sign” (fat extrusion during the biopsy).^[8]

Treatment is almost always surgical in adults when compared to children and invariably leads to resection of the involved bowel segment with subsequent primary anastomosis.

Majority of authors recommend surgery as the standard method of treatment for every colonic lipoma >2 cm in size.^[8] Surgical treatment includes resection, colotomy with local excision, limited colon resection, segmental resection, hemicolectomy, or subtotal colectomy. The choice of the surgical intervention mainly depends on the lipoma size, location, and the presence or absence of definite preoperative diagnosis. Few cases of

successful laparoscopic resection of colonic lipomas have been reported in literature. It is recommended to use laparoscopic resection in the face of a known lipoma because the patient enjoys the benefit of shorter period of ileus, shortened disability, less postoperative pain, and shorter hospital stay.^[8]

Endoscopic mucosal resection using the electrocautery snare is preferred technique for the excision of lipomas smaller than 2 cm in size. However, endoscopic removal of sessile or broadly based lipomas may result in a high rate of perforation and hemorrhage.

Although intussusception themselves have a good prognosis, it is often the nature of the lesion causing the intussusception which determine prognosis. Mortality for adult intussusception increases from 8.7% for the benign lesions to 52.4% for the malignant variety.^[2]

CONCLUSION

Adult intussusception is rare and presenting symptoms are often nonspecific and chronic which can lead to delay in diagnosis. Often an underlying trigger or nidus is present in adult intussusception and treatment is almost always surgical. Therefore, keeping a high index of suspicion combined with early diagnosis with colonoscopy or CT scan can prevent serious complications such as hemorrhage, intestinal gangrene, and perforation.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the

patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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