

ILEO-COLO-RECTAL INTUSSUSCEPTION SECONDARY OF CAECAL LIPOMA SIMULATING STRANGULATED RECTAL PROLAPSUS

Abstract :

Acute intussusception determines a severe occlusive picture; it is a rare clinical entity in adults. It is most often hailic, difficult clinical diagnosis, but facilitated by radiological examinations, mainly the abdominal computed tomography, allows to make the diagnosis of certainty and to discover a possible etiology. The treatment of intestinal intussusception in adults is always surgical, the use of pathology is necessary for diagnostic confirmation; it is usually secondary to a sub mucosal lipoma. We report the case of an urgently admitted patient for an ileal-coeco-colo-rectal invagination prolapsed across the anus, presenting as a picture of strangulated rectal prolapse.

Résumé :

L'invagination intestinale aigüe détermine un tableau occlusif grave, c'est une entité clinique rare chez l'adulte. Elle est le plus souvent grêlique, de diagnostic clinique difficile, mais facilité par les examens radiologiques, principalement la tomodensitométrie abdominale, qui permet de poser le diagnostic de certitude et de découvrir une éventuelle étiologie. Le traitement de l'invagination intestinale aigüe chez l'adulte est toujours chirurgical, le recours à l'étude anatomopathologique s'avérer nécessaire pour la confirmation diagnostique, elle est secondaire généralement à un lipome sous muqueux. Nous rapportons le cas d'une patiente admise en urgence pour une invagination iléo-coeco-colo-rectale prolabée à travers l'anus, se présentant sous forme d'un tableau de prolapsus rectal étranglé.

Keywords : *Acute intestinal intussusception, Caecal lipoma, Strangulated rectal prolapsus*

Mots clés : *Invagination intestinale aigüe, lipome caecal ; prolapsus rectal étranglé*

INTRODUCTION :

Intestinal intussusceptions is defined by telescoping and pénétration of an intestinal segment in the down stream segment. It defines an occlusive table potentially serious due to the risk of intestinal ischemia [1].It is a rare pathology in adult patients and represents 1 % of the intestinal occlusions in

Europe and 3 % in Africa [2]. It is generally secondary to malignant tumors such as adenocarcinomas of the ileo-cecal valve or to benign tumors such as lipomas polyps and Meckel diverticula [3].

We report a rare case of a ileo-colo-rectal intussusception on cecal lipoma shown in the form of strangulated rectal prolapse.

OBSERVATION :

A patient aged 41 years old, with no specific pathological antecedents, admitted to visceral surgical emergencies, because of the supervention of prolapsed mass by the rectum that was irreducible painful, evolving for 3 day and combined with pelvic pain, vomiting, diarrhea and episodes of rectal bleeding, all evolving in a context of fever and alteration of the general condition. When clinically examined, the patient was a febrile, hemodynamically and respiratorily stable, Performance status (PS): 1, slightly discolored connective, the abdomen was slightly distended with hypogastric sensitivity, no palpable mass, while the ganglionic areas and the hernia holes were free. The exam of the perineum detected the presence of voluminous rectal prolapse, with inflamed congestive aspect painful when palpated irreducible. The rectal palpation with presence of rectal bleeding (Figure 1).

The surgical intervention was indicated in emergency in case of strangulated prolapse symptomatology and the hypogastric sensitivity. Median above and subumbilical laparotomy was carried out. The surgical exploration detects ileo-caecal-colo-rectal intussusception over caecal mass with exteriorisation of the intussusception flange through the anus (Figure 2). The operative act consisted of right ileo-hemicolectomy after disintussusception, with ileo-colostomy and draining of the Douglas and the right parietal colic gutter by two Redon drains.

The post-operative aftermaths marked by the infection of the operative site (IOS) cured by antibiotherapy and bidaily local care. Stoma became functional with the retake of the transit and alimentation at postoperative (D1), the first lever a was precocious, recommenced on D1 postoperative. Drains brought some Cc of sero-hematic liquid and drawn out on D3 postoperative. The patient was allowed to leave hospital on D3 postoperative.

The histopathological exam of the operative part objectified a morphological aspect evoking submucous lipoma ulcerating the surface coating and made complicate the intestinal intussusception.

The resection limits were congestive with reaction adenitis. Six months later the patient was readmitted to re-establish the ileo-colic continuity, the postoperative aftermaths were simple, allowing her to leave hospital on the D5 post-operative. The retreats 2 years and the patient was followed in consultation for surveillance.

DISCUSSION :

Acute intestinal intussusception (All) is a clinical entity that is rare in adults it represents only 1 to 5% of acute intestinal occlusions [4]. The acute intestinal intussusception (All) is most often of the small bowel (48% - 70%), ileo-colic (25% - 40%) and rarely genuinely colic (5% - 18%). It is generally secondary to an intestinal lipoma. The latter is seated most often on the cecum or the ascending colon [6]. The tumor of the initial sub-mucous develops towards light and exerts a genuinely mechanical phenomenon on by pushing the mucus [1] with intermittent phenomena of colo-colic intussusception behind partial obstruction of the colic light and mucous ulcerations [7]. The supervision of acute intestinal intussusception being directly correlated to its size when it is larger than 2 cm according to different studies [7]. We report the case of a patient admitted to emergently for ileo-cecal-colo-rectal prolapsed intussusception through the anus, shown in the form of strangulated rectal prolapse.

Intestinal intussusception in adult patients can be hard to recognize. It can evolve within different clinicalable spermeated by an acute intestinal occlusion in 10 to 30% of forms in Europe against 75% to 100% in Africa [2]. The subocclusive table of progressive supervision extending from a few days to general weeks. The non specific abdominal syndromes (modification of the transit, diffus abdominal pain, occult bleedings...).

The classical triad of All combines abdominal paroxystic pain, bleeding diarrhea and a palpable mas that is present only in 9,8% of cases in adult patients [2]. Whatever the initial clinical presentation, the diagnosis is often carried out using imagery (echography, scanner) and more scarcely through exploratory surgery.

Radiologically, the cliché of the abdomen without preparation can show hydro-air levels and specify the occlusion seat [5].

Echography is performed to carry out the diagnosis of both the intestinal intussusception and of the well-limited hyper-echogenous tumor lesion surrounded by anormal intestinal wall [5]. It reveals the classical image over transversal cutting sit reveals an image "in sandwich" or of "pseudo-kidney" [1]. However, its performances are limited by the abundance of gases due to the intestinal occlusion as it is the depending operator [2].

Tomodensitometry realised in emergency allowed to increase the sensitiveness of the diagnosis. It is more efficient than echography [1] and enables to push to undoubted diagnosis in the adult patient and to detect a prospective etiology [5]. It allows to diagnose the obstructive syndrome, its mechanism intussusception as it happens, its precise localisation, the signs of intestinal sufferings [4,6] and to show its cause in 71% of the cases intraluminal and extraluminal masses [1,2]. The treatment of acute intestinal intussusception in adult patients is always surgical and does not leave space for any reduction by hypertension under radiologic control [5,7].

The first reduction can be tempted in idiopathic forms [1] when a long segment is implied [2,8] and that its resection can expose to a short small bowel syndrome.

The temptation of disintussusception exposes to the risk of intestinal perforation [1]. However, it must not be tempted if signs of intestinal ischemia of inflammation or if malignancy are suspected [2]. When

the intestine is completely unreduced after disintussusception, palpation allows –in most cases- to detect the causing obstacle [8] and allows to better assess the limits of the resection and sometimes to reduce its extension mainly in case of benign tumor [1].

A more or less extended resection imposes itself with respect to the carcinological rules when an evidently malignant tumor is detected [1].

When disintussusception is impossible or when the intussusception flange is not obviously viable, the resection takes a way this area in block, while taken care to carry out anastomosis on the intestinal area that is healthy and well vascularised [8].

In our case, the necessity of disintussusception was advised due to the extension of the invaginated segments, including the ileum, the cecum, and the colon with exteriorisation of the intussusception flange through the anus.

The anatomopathological study is required to confirm the diagnosis and must be completed by immunohistochemical study in certain cases [1]. Lipoma develops in 90% of the cases depending on the adipocytes of the sub-mucosa. More scarcely it develops in the sub-serous area [7].

The prognosis of the AI in the adult is related to the duration of the evolution. The extension of the lesions and to the nature of the cause [5].

CONCLUSION :

Acute intestinal intussusception in adult patients is scarce. Giant ileo-colo-colic intussusception on the caecal lipoma remains an exception the clinical symptomatology can be aspecific, hence the usefulness of scanner in the charge allowing to diagnose and to specify the seating of the occlusion and to detect the cause [5].

The surgical treatment is required and the surgical act depends on the peroperative observations in the presence or non presence of intestinal necrosis and of tumor (whether benign or malignant) to take away the obstruction and put forward the exact diagnosis.

Figure:

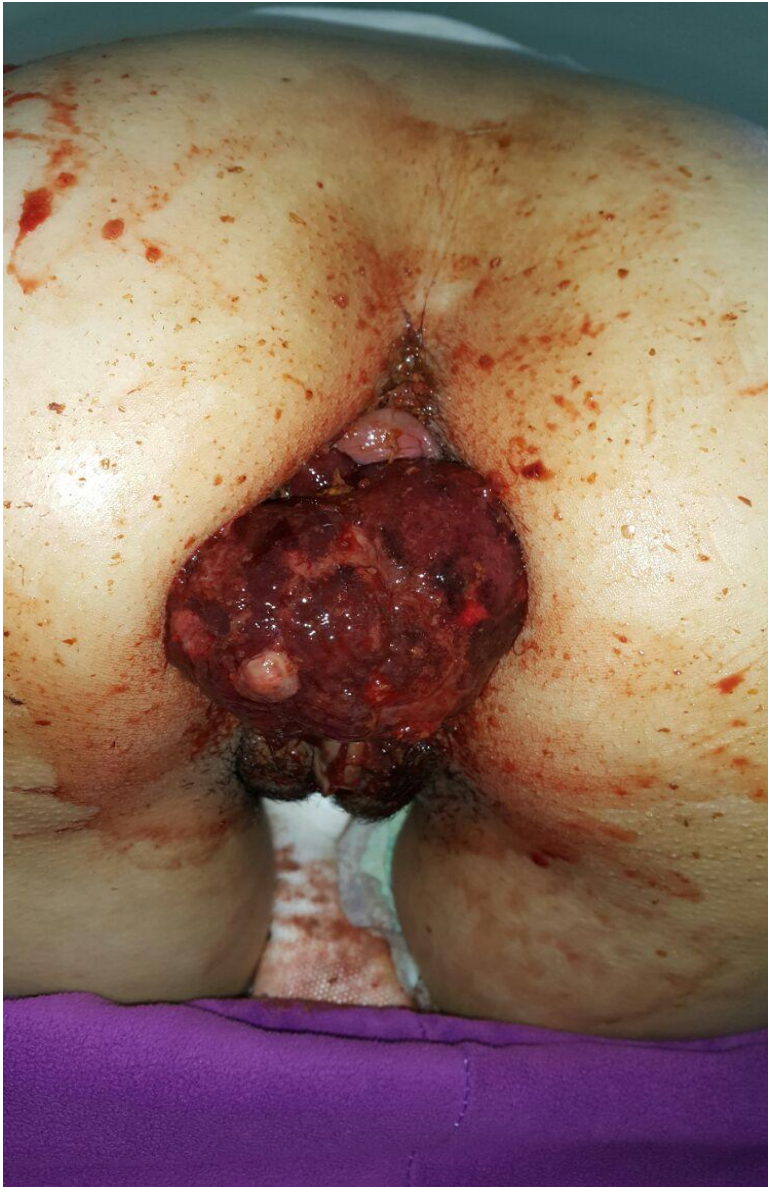


Figure 1 : voluminous rectal prolapse.

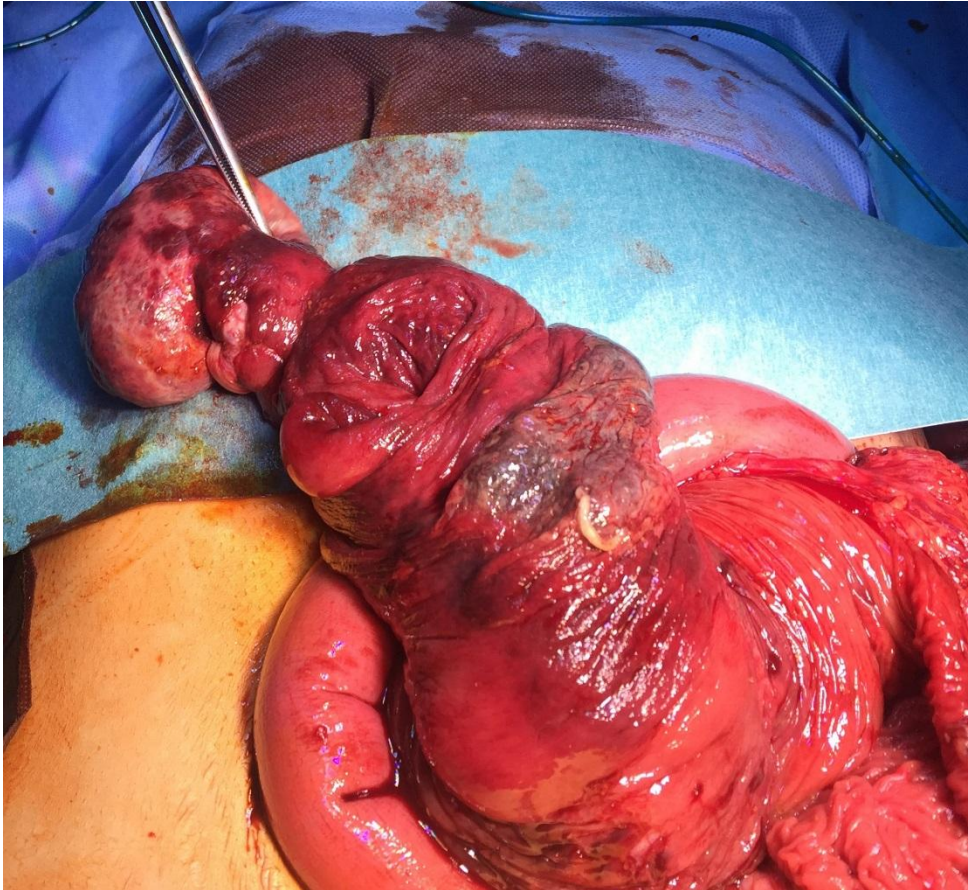


Figure 2: ileo-caecal-colo-rectal intussusception over caecal mass with exteriorisation of the intussusception flange through the anus.

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