



CASE REPORT

CAECOCOLIC INTUSSUSCEPTION MIMICKING APPENDICULAR LUMP

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ABSTRACT

Intussusception is a rare encounter in adults. Its diagnosis can be delayed because of its long standing and non-specific symptoms and most of the cases are diagnosed on emergency laparotomy. Here, we present a case of 50 years old female who was previously diagnosed an appendicular mass, revealed caecocolic intussusception at emergency laparotomy.

Key words: Appendicitis, Appendicular lump, Intussusception.

INTRODUCTION

An acute appendicitis is one of the most common surgical emergencies encountered by a general surgeon. In about 2-6% of cases, an appendicular mass has already developed at presentation.¹ There is an established trend to treat the Appendicular lump conservatively which may be adequate in children but in adults one has to be very specific regarding diagnosis which should be confirmed by C.T. abdomen as other pathological conditions such as Intussusception, tumour, lymphoid hyperplasia may simulate an Appendicular lump. Here, we present a case of caecocolic intussusception presenting as an appendicular lump.

CASE REPORT

A 50 years old lady presented in emergency with the chief complaint of colicky abdominal pain since 5 days which was more on the right iliac fossa which gradually got worsened. She had anorexia but no vomiting, had anorexia and mild abdominal distension but no fever. Her bowel and bladder habit were normal at presentation. On examination, the abdomen was slightly distended and there was tenderness, mild guarding and a mass on right iliac fossa. The mass was about 2x3 cm and slightly tender. Rest of the examination revealed normal findings.

All her hematological, serological, renal function test, electrolytes and x-ray of abdomen and chest were within normal limits. Ultrasonography of abdomen and pelvis showed a complex mass at right iliac fossa measuring 3.35 x 4.5 cm with minimal interloop fluid collection at that particular area.

She was kept with a provisional diagnosis of appendicular lump and conservative management was instituted with nil per oral, iv fluids, iv antibiotics and analgesics. For three days, she showed an improvement and oral diet was started then. But, again from next day, she started again complaining of similar symptoms. On examination, the mass was increased in size and now mobile and more tender. Ultrasonography was sent which showed the mass increasing in size and the collection also extended to pelvis.

She was planned for an emergency surgery and exploratory laparotomy was performed which showed caecum intussuscepting into the ascending colon with some reactive peritoneal collection (figure 1). A limited right hemicolectomy was performed with primary ileocolic anastomosis. The post-operative recovery was uneventful. He was discharged after stitch removal. The histology confirmed submucosal lipoma of caecum.



Fig 1: Caecocolic intussusception

DISCUSSION

An appendiceal mass or a lump is an inflammatory mass composed of inflamed appendix with omentum, caecum, terminal ileum and mesoappendix at times sigmoid colon, right tubes and ovaries in females which is a protective mechanism to prevent spread of infection.² It forms a spectrum of diseases ranging from a phlegmon to an appendiceal abscess. Although there are three approaches to the treatment- conservative, immediate surgery and conservative treatment with interval appendicectomy after resolution in 6-8 weeks, the conservative management is mostly advocated.³

Intussusception is uncommon in adults when compared to pediatric population. It is estimated that only 5% of all intussusceptions occur in adults and approximately 5% of bowel obstructions in adults are the result of intussusceptions. In more than 90% of cases, an identifiable lesion resulting in a lead point is demonstrable 50% of which is malignant.⁴ The mean age is 54.4 years, and the male-to-female ratio is 1:1.3.⁵ Cases can be either acute or chronic, and abdominal pain is the most common symptom (71-100%), followed by nausea and vomiting in 40-60% of the cases. Bleeding per rectum was seen in 4-33% of the cases.⁶ This wide range is usually based on the site of the intussusception, with colonic ones bleeding more frequently than the ileal varieties. Acute abdominal pain with guarding is present in only about 50% of the cases.⁷ Abdominal masses are palpable in less than 10% of patients.⁸

According to location intussusception are of four types: ileo-colic, ileo-ileo-colic, colo-colic and small bowel intussusception (jejuno-jejunal and ileo-ileal).⁹

Malignant or benign lesions in the terminal ileum and caecum, such as adenoma, lymphoid hyperplasia or lipoma causing intussusception, can mimic appendicular mass, such as in our case. Lipoma is the commonest mesenchymal benign tumour of the colon, although rare, accounts for 21% of colonic intussusception. They are usually small and frequently seen in the right colon, especially at the caecum in elderly women.¹⁰

CT Scan is the most reliable investigation. It is described as a "target mass" on CT Scan with intussusception forming the center and the edematous intussusception forming the external ring.¹⁰ Other investigations like ultrasonography,^{11,12} colonoscopy or flexible sigmoidoscopy,¹³ upper GI series,¹⁴ barium enema,^{10,15} can be used according to the clinical situation.

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. In large bowel resection without reduction of the intussusception is advocated. The majorities of colonic intussusceptions are malignant and require formal resection. Reduction of the intussusception in large bowel is not advised because of the possibility of malignant seeding. Reduction can be attempted in small bowel if the segment involved is viable or malignancy is not suspected.¹⁶

CONCLUSION

Benign and malignant lesion of the terminal ileum and caecum such as adenoma, lymphoid hyperplasia or lipoma causing intussusception, can mimic appendicular mass, so a high index of suspicion is needed if the patient does not improve clinically subsequently. If possible a diagnosis should be confirmed by radiology especially CT if possible. Resection of the involved segment is advocated in adult as there is lead point in majority of the cases.

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