



Jejunioleal intussusception : A case report

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ABSTRACT

Small bowel intussusceptions (SBI) are much less common than the ileocolic variety, with jejunioleal and duodenojejunal intussusceptions being the rarest types of all. SBI may be difficult to diagnose preoperatively, with a consequent increase in ischemic complications, secondary to delayed surgery. It is different clinically from the classic ileocolic intussusception. Not only it is seen in a different age group, but the presentation is different and there is more chance of finding a pathological lead point.

INTRODUCTION

An intussusception is a medical condition in which a part of the intestine invaginates into another section of intestine, similar to the way the parts of a collapsible slide into one another. This can often result in an obstruction. In the most frequent type of intussusception, the ileum enters the cecum. However, other types occur, such as when a part of the ileum or jejunum prolapses into itself. Almost all intussusceptions occur with the intussusceptum having been located proximally to the intussusciptens. This is because peristaltic action of the intestine pulls the proximal segment into the distal segment. There are, however, rare reports of the opposite being true.

We present a rare and interesting case of jejunioleal intussusception.

CASE REPORT

This case, a 1 month old infant, known case of cleft lip and cleft palate, first born, to a non consanguineously married couple, was admitted to our NICU with loose stools, vomiting and respiratory distress for the past 2 days. Baby was on top feeds from birth. On admission baby was tachypnoeic with chest indrawing and severely dehydrated. In view of severe uncompensated metabolic acidosis aggressive fluid therapy and bicarbonate correction were given. Tachypnea and signs of severe dehydration gradually settled. From day 3 of admission baby started having progressive abdominal distension, followed by bilious Ryle's tube aspirate and blood in stool. Abdominal X-ray showed distended bowel loops and further investigations showed

features of septicemia. A provisional diagnosis of septic ileus was made and aggressive antibiotic therapy was started but baby continued to have the above symptoms and signs. Hence baby was taken up for an emergency exploratory laparotomy which showed jejunioleal intussusception with gangrenous bowel. Resection anastomosis was done and postoperatively baby was doing well. On post op day 4 baby started passing stool and on post op day 7 baby was started on oral feeds. Baby was discharged on post op day 11 with full feeds and advised a regular follow up. Baby was advised cleft lip and palate repair after 6 months.

DISCUSSION

Small bowel intussusceptions (SBI) are much less common than the ileocolic variety, with jejunioleal and duodenojejunal intussusceptions being the rarest types of all¹. Intussusception is one of the most common causes of an acute abdomen in children and has a characteristic clinical picture of vomiting, red 'currant jelly' stools, severe colicky abdominal pain and mass. It can occur at any age, but the peak incidence is usually between the fifth and ninth months of life. The incidence of acute intussusception is reported to range from 0.66 to 2.24 cases per 1000 children².

More than 80% of intussusceptions are of the ileocolic type². Small bowel intussusception is unusual, representing 1-10% of all intussusceptions but up to 50% of cases in older children. Ileoileal, jejuniojejunal, jejunioleal and duodenojejunal intussusceptions are described in descending order of frequency. Subacute presentation of SBI is typical and therefore, as in our case, difficult to diagnose preoperatively, leading to an increased risk of ischaemic complications^{3,4}. An intussusception length



Figure 1: Showing gangrenous bowel



Figure 2: Resected bowel

>3.5cm has been reported as a sensitive and specific predictor of those SBIs that require surgical intervention, as compared to those that will resolve spontaneously^{5,6}. While ultrasound remains the primary imaging modality used both to diagnose intussusception and for the evaluation of an abdominal mass lesion, the clinical condition of the patient may dictate that CT be sometimes used as a first-line investigation.

CONCLUSION

Small bowel intussusceptions are much less common than the ileocolic variety, and requires a high degree of suspicion and knowledge to diagnose and prevent the complications.

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