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JEJUNOJEJUNAL INTUSSUSCEPTION: AN IDIOPATHIC AND OFFBEAT HAPPENING IN A MIDDLE-AGED, HEALTHY, FEMALE PATIENT TEN DAYS AFTER LAPAROSCOPIC CHOLECYSTECTOMY

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INTRODUCTION

Intussusception is an exceptional abdominal emergency amongst adults. It consists in the imprisoning of a proximal portion of the bowel and its mesentery (*intussusceptum*) inside the following section of the gastrointestinal tract (*intussuscipiens*), then, lymphatic, venous and arterial circulation decreases: edema, obstruction, ischemia, perforation and peritonitis might appear, alongside severe abdominal pain, vomits, bloody stools and shock. Most affect the ileocolic junction. Other configurations are: jejunojejunal, jejunoileal, ileoileal and colocolic intussusception.

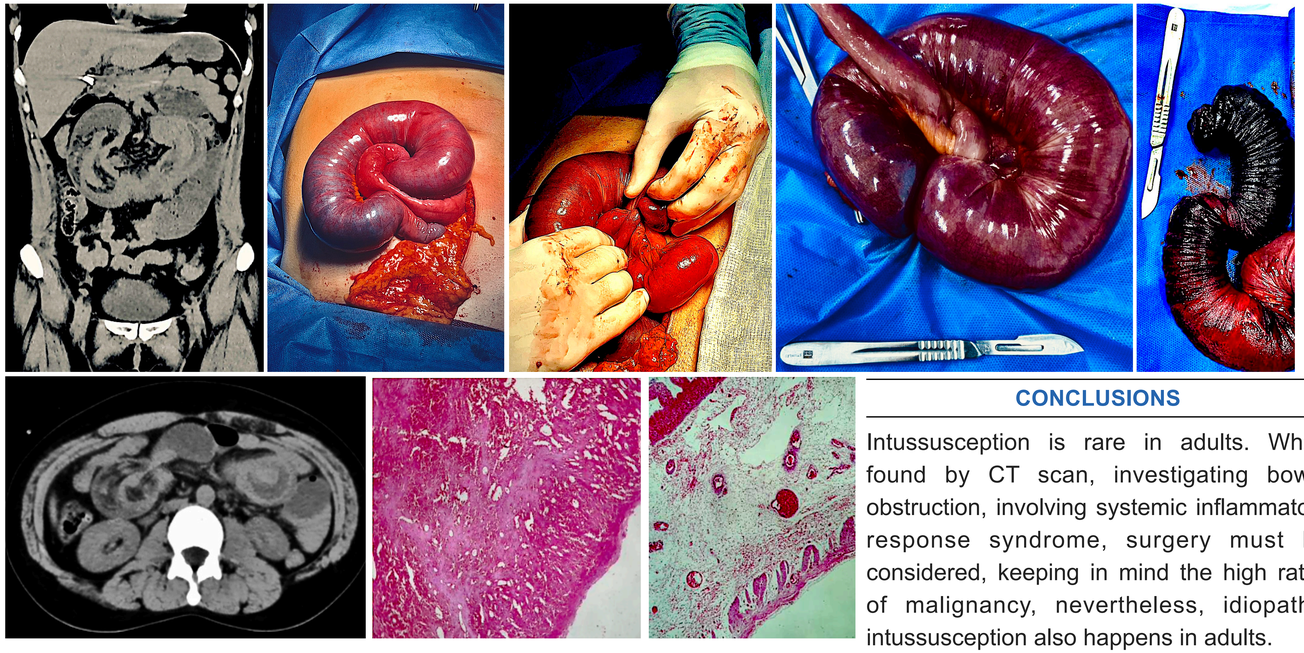
- Most common cause of abdominal emergency at ages of 6-36 months. 75% are idiopathic, due lymphoid tissue hypertrophy related to viral infections.
- Tumors and polyps of the *intussusceptum* are known causes. 0.5-1% of adult bowel obstructions are associated to intussusception and up to 90% of them have an organic demonstrable lesion.
- Ultrasonography and computed tomographic (CT) scan are highly valuable for diagnosis.

CASE PRESENTATION

- A 45 years old woman arrives to the emergency room with 24 hours of diffuse abdominal cramping, biliar emesis and hematochezia. Ten days before, she had an elective uncomplicated laparoscopic cholecystectomy due chronic cholecystitis. Pulse was 115 beats per minute, rest of vital signs were normal.
- The three laparoscopic ports had normal appearance, she had hypoactive bowel sounds and a “sausage-form" mesogastric palpable mass, without rebound tenderness.
- Laboratory revealed leukocytosis (25.5 109/L), serum lactate 2.3 mg/dL and normal electrolytes and liver enzymes. Abdominal CT scan showed a "target sign" and "pseudokidney sign”, considered pathognomonic.
- Midline laparotomy was performed: 3.6 feet passing the duodenojejunal flexure, an irreducible jejunojejunal intussusception was found; 2 feet of the proximal portion showed ischemia signs. The portion of intussusception was resected (2.6 feet).
- An end-to-end manual double-layer enteric anastomosis was performed, having macroscopically normal margins of tissues. Prophylactic antibiotics were administered.

MANAGEMENT AND RESULTS

Hematochezia ceased 48 hours postoperatively; mild periincisional pain was reported during the stay. Patient's discharge was four days after surgery; afebrile, orally fed, passing gas adequately and having normal defecation. Pathology report described intussusceptum's transmural necrosis, mesenteric vessels thrombosis and the absence of malignant cells.



CONCLUSIONS

Intussusception is rare in adults. When found by CT scan, investigating bowel obstruction, involving systemic inflammatory response syndrome, surgery must be considered, keeping in mind the high rates of malignancy, nevertheless, idiopathic intussusception also happens in adults.

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