

A Case of Ileo-Colo-Colic Intussusception Presented as Acute Abdominal Pain

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Abstract: *Intussusception is one of the classic Case of paediatric Acute abdomen. It is defined as telescoping of one segment of bowel into other. It is one of the most common paediatric emergencies, and important cause of small bowel obstruction in children. If left untreated leads to fatal complications.*

Keywords: Intussusception, Mesentric lymph nodes, Lead point, Ileo-colic

1. Introduction

Intussusception is defined as the telescoping of one segment of bowel (Intussusceptum) into another (Intussusciens), usually proximal segment into the distal segment of bowel [1]. In this case Distal ileum as Intussusceptum and transverse colon as Intussusciens.

As the mesentery of the proximal bowel is drawn into the distal bowel, it is compressed, which results in venous obstruction and odema of bowel wall. If reduction of the intussusception does not occur, arterial insufficiency occur and bowel wall necrosis follows progressing to strangulation, transmural gangrene, perforation and peritonitis, which in turn will lead to morbidity and death of patient. In the past due to lack of diagnostic modalities, the morbidity and mortality of intussusception was very high [2].

Hence to determine the clinical profile of patients with intussusception and to delineate the role of ultrasonography in early diagnosis of this condition the present study was initiated.

2. Case Presentation

This is a 1-year-old male child presented with acute abdominal pain without vomiting and constipation. Patient having complain of abdominal pain of sudden onset. Patient had no similar complain in the past.

Intravenous analgesics were administered for pain control.

Physical examination showed apparent tenderness without Abdominal lump formation. The patient was admitted for further evaluation and treatment on emergency basis.

All the haematological investigation were within normal limits.

Ultra sonography suggestive of approximately 9 cm segment of bowel with its mesentery within the bowel with preserved vascularity led to diagnosis of intussusception



Emergency Exploratory laparotomy done by keeping horizontal incision above the umbilicus. An ileo- Colo-colic Intussusception found with distal ileum as intussusceptum extending up to transverse colon which was reduced manually(fig1). Enlarged Lymph nodes was found of size of approximately largest of 1*1*1 cm3(Fig-2). Enlarged lymph nodes was excised. Caecopexy done for redundant large bowel. There was minimally inflamed appendix and for which appendicectomy was done.

A drain was kept in pelvis. Post operative period was uneventful.

Sips started on Post operative day 2. Drain was removed on post operative day 4 and Patient discharged.

3. Conclusions

Intussusception is one of the most common paediatric emergencies. Our study showed a higher male preponderance, with highest number of cases seen in the age

group of 0-1 years. Two peaks of seasonal variation were observed in our study one in winter and other in summer.

Most of the clinical symptoms were overlapping the predominant symptoms being excessive crying/ Abdominal pain, Vomiting and mass per abdomen. Majority of cases

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were idiopathic and are of ileo-colic type. Secondary intussusception occurs due to lead points. Most common lead points in our study are mesenteric lymph nodes, Meckels diverticulum, gut associated lymphomas and appendix

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References

- [1] Welch K.J., Randolph J.S, Ravitch M.M, et al, Paediatric surgery: Intussusception,4th Ed.Vol.2, Chap.88, 868-881pp. |
- [2] Swenson's pediatric surgery. 5th Ed., Chapter 27, 221-229 pp.
- [3] Stringer MD, Pablot SM, Brereton RJ: Paediatric intussusception.British Journal of Surg.79:867-876,1992.
- [4] Hamby L.S., Fowler C.L., Pokorny W.J.: Intussusception.In:Donnellan W.L.,ed. Abdominal surgery of Infancy and childhood, Australia:Harwood;1996:1
- [5] WHO/V&B/02.19 (www. WHO.int/vaccines.documents/)
- [6] Ravitch M.M, MuCune R.M. Jr: Intussusception in infants and children. J Pediatr 37:153,1950.
- [7] Davis C.F, McCabe A.J., and Raine P.A.M.,The ins and outs of intussusceptions :history and management over the past fifty years.J.pediatr Surg:May 200