Enteric intussusception in adults

Dear Sirs,

We read with great interest the recent article of C. Toso et al. [Swiss Med Wkly 2005;135:87–90] [1], in which the authors report on a group of patients managed for intussusception over a 17-year period and review the literature. We agree with their views on the importance of early surgical management, but disagree with the emphasis placed on the utility of computed tomography (CT) as the diagnostic instrument of choice.

A 42-year-old man was recently admitted to our Surgical Department complaining of severe pain in the upper abdomen and with bile-tined vomiting. His past medical history was negative for medical diseases or previous interventions. Physical examination showed diffuse hyperperistalsis and abdominal tenderness, but no abdominal masses were detected. The laboratory findings appeared normal except for slight hypokalaemia and hyperglycaemia. Abdominal x-ray revealed only sparse air-fluid levels, while ultrasonography (US) and CT scan were not helpful in clarifying the diagnosis. A volvulus was suspected and the patient was preoperatively treated by nasogastric tube positioning, fluid resuscitation and antibiotic prophylaxis. Exploratory laparoscopy showed a 30 cm tract of intussuscepted ileum, 40 cm distant from the ileocecal valve (fig. 1). Due to its severe ischaemic state and the impossibility of reducing the intussusception, the involved tract was resected laparoscopically. A polypoid haematoma was found in the specimen. The postoperative course was normal and the patient was discharged on the 3rd postoperative day.

As reported by the authors, the typical clinical presentation of adult intussusception is abdominal pain with tenderness and a palpable abdominal mass, while the pathognomonic “currant jelly stool” is more frequent in paediatric patients. In our case the diagnostic difficulty arose from the absence of a palpable abdominal mass and the limited utility of US and CT scan. However, the characteristic radiological findings of “target”, “pseudokidney” or “sausage” signs depend on factors such as the oedematous wall of the intussusception, the tract length, the cut axis, etc... [2].

We agree with the authors that recognition of the intussusception in an adult patient may often be difficult and may represent a major challenge for an inexperienced surgeon, due to the importance of prompt surgical treatment. What we consider essential is accurate clinical evaluation, which in some cases may be assisted by radiological investigations. We do however advocate the use of laparoscopy, especially when the diagnosis is unclear [3].

Emanuele Baldassarre, Ilaria Properi Porta, Giovanni Torino, Gabriele Valenti, Department of Surgery, San Pietro Hospital, Fatebenefratelli, Rome

Correspondence: Emanuele Baldassarre, MD Viale I Maggio, 74 00046 Grottaferrata (Rome) Italy E-Mail: emanuele.baldassarre@uniroma1.it

References

Author’s reply to Baldassarre et al.

I am grateful to the Editors for allowing me an opportunity to address the comments of Baldassarre et al. This case further emphasizes the inherent difficulty of diagnosing intussusception in adults. When radiological examinations fail to provide a definitive diagnosis in patients with symptoms of bowel obstruction, additional investigations are required and laparoscopy is clearly a useful element.

It is important to note, however, that intussusception is a rare condition and CT imaging, prior to invasive laparoscopy, may provide accurate diagnoses for numerous alternative aetiologies needing to be assessed in patients with bowel obstruction.

In the case of intussusception, CT imaging is capable of furnishing an accurate diagnosis in approximately 80% of patients [1–3]. Furthermore, associated abnormalities, such as bowel obstruction and underlying tumour, may potentially be identified.

In general, patients with acute or chronic bowel obstruction should undergo a step-by-step process of diagnosis including physical examination, radiological examination (CT) and, in some cases, laparoscopy. Some of them will finally be diagnosed with intussusception.

Christian Toso

Correspondence: Christian Toso Clinic of Abdominal and Transplant Surgery University Hospital 24 rue Micheli-du-Crest CH-1211 Geneva 14 Switzerland E-Mail: Christian.toso@hcuge.ch

References
The many reasons why you should choose SMW to publish your research

What Swiss Medical Weekly has to offer:

• SMW’s impact factor has been steadily rising, to the current 1.537
• Open access to the publication via the Internet, therefore wide audience and impact
• Rapid listing in Medline
• LinkOut-button from PubMed with link to the full text website http://www.smw.ch (direct link from each SMW record in PubMed)

• No-nonsense submission – you submit a single copy of your manuscript by e-mail attachment
• Peer review based on a broad spectrum of international academic referees
• Assistance of our professional statistician for every article with statistical analyses
• Fast peer review, by e-mail exchange with the referees
• Prompt decisions based on weekly conferences of the Editorial Board
• Prompt notification on the status of your manuscript by e-mail
• Professional English copy editing
• No page charges and attractive colour offprints at no extra cost

We evaluate manuscripts of broad clinical interest from all specialities, including experimental medicine and clinical investigation.

We look forward to receiving your paper!

Guidelines for authors:
http://www.smw.ch/set_authors.html

Impact factor Swiss Medical Weekly

All manuscripts should be sent in electronic form, to:

EMH Swiss Medical Publishers Ltd.
SMW Editorial Secretariat
Farnburgerstrasse 8
CH-4132 Muttenz

Manuscripts: submission@smw.ch
Letters to the editor: letters@smw.ch
Editorial Board: red@smw.ch
Internet: http://www.smw.ch