

## 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-tinged vomit. 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 ileo-coecal valve (fig. 1). Due to its severe ischaemic state and the impossibility of reducing the intussusception, the involved tract was resected laparoscopically. A polypoid hamartoma was found in the specimen. The postoperative course was normal and the patient was discharged on the 3<sup>rd</sup> 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].



**Figure 1**  
The intussuscepted tract resected.

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].

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### 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 emphasises 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.

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