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COLORECTAL INTUSSUSCEPTION IN A PATIENT WITH NON-HODGKIN'S LYMPHOMA

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Summary

We describe a case of non-Hodgkin's lymphoma of the large bowel with sole presentation as intussusception that was treated with resection and end-to-end anaestomosis, followed later by chemotherapy..

Introduction

Intussusception occurs when one segment of bowel telescopes into an adjacent segment, resulting in obstruction and possible ischemic injury[1,2]. Once intussusception occurs, bowel obstruction develops. The resultant edema and vascular compromise can lead to necrosis and gangrene if diagnosis is delayed. It is more common in infants and is a rare cause of intestinal obstruction in adults where there is usually an underlying pathology[1]. Benign and malignant tumors are the cause of intussusception in nearly two thirds of adult cases.

Intussusception is rarely reported as a complications of non-Hodgkin's lymphoma (NHL)[3].

We report a young patient with NHL in whom intussuption was the only clinical presentation.

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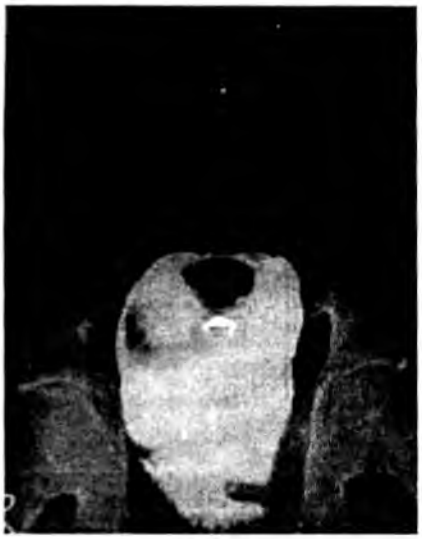
Case Report

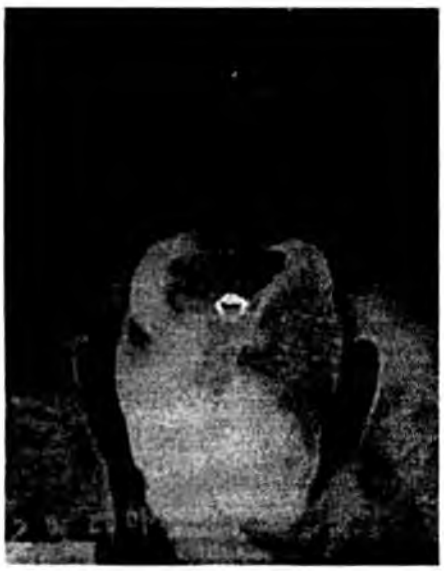
A 20-year old male was admitted to the Basrah Military Hospital with 2 month history of colicky abdominal pain, bleeding per rectum and history of a mass protruding per anus that was replaced manually by the patient with difficulty. The mass prevented him from passing motion unless he replaced it manually. It protruded spontaneously on sitting position without straining or defecation. There was no history of fever, weight loss, sweating, or pruritus. Haemorrhoidectomy was done for him in another hospital 2 weeks before admission. On examination, there was no peripheral lymphadenopathy or abdominal mass.

Investigations included barium enema showing appearances classic of intussuscption (figure 1a,b) with rounded filling

defect in the lumen and peripheral streaks of barium tracking to a variable extent between the intussuceptum and intussuceptient and the barium could not pass cephalad despite the increase in hydrostatic pressure. Ultrasound of abdomen was unremarkable because of gases in lower abdomen. Rigid sigmoidoscopy showed a mass protruding in the rectum, from above, with thickening of mucosa.



(a)



(b)

Figure 1 (a,b). Baruim enema with classic central filling defect.

Laparotomy was done for him via lower mid line incision. There was intussusception of sigmoid colon into the rectum that was difficult to release, and was eventually resected with end-to-end anastomosis. A vent colostomy was done for him.

Gross biopsy specimen was a mass 8cm from rectosegoimd area with histopathology showing diffuse large cell type-high grade NHL involving the full thickness of rectum with free resected rectal margin.

Postoperative screening with full blood count, upper gastrointestinal endoscopy and bone marrow study was normal. There was no clinical evidence of involvement of other sites of the body. He was sent for chemotherapy.

Discussion

Intussusception is rare in adults[4]. Overall, adults account for only 5 to 10 percent of intussusceptions cases[5].

Most cases of adult intussusception have a demonstrable lead point[6]. Forty-eight percent of the adult colonic intussusception are secondary to malignancy and 17% of small bowel intussusception are secondary to malignancy.

This patient presentation was rather vague and prolonged over two months. Adult intussusception usually presents without the classic symptoms[4], and is likely to appear insidiously, with vague abdominal symptoms, and the diagnosis may be difficult.

The patient we report presented with prolapse of intussuscptum from his anus, which is a recognized sign in intussusception[7]. In such a case, diagnosis of intussusceptions is usually apparent, with a clinical history of crampy abdominal pain and almost immediate recurrence of the apparent prolapse after reduction, as we have seen in this patient.

The gastrointestinal tract is the most common extra nodal site of NHL[8]. It involves the gastrointestinal tract at autopsy in 50%-60% of patients dying of

NHL[9]. NHL of the colon constitutes 20%-30% of primary gastrointestinal lymphomas[8]. It occurs most often in caecum and rectum. Gastrointestinal bleeding, intestinal obstruction and perforation may complicate the disease at any time during its course[9].

The primary treatment of lymphoma-associated intussusception in adults is always surgical[10].

References

1. Stubenbord WT, Thorbjamarson H. Intussusception in adults. Ann Surg 1970;172:306-310.
2. Agha FP. Intussuception in adults. Am J Roengenol 1986;146:527-531.
3. Harakati M S, Aboudlkhair OA. Ileo-colic intussusception in a patient with non-Hodgkin's lymphoma .Saudi Med J 2001;22:638-640.
4. Gordon RS, O'Dell KB, Namon AJ, Becker LB. Intussusception in the adult-a rare disease. J Emerg Med 1991; 9:337-342.
5. Brayton D, Norris WJ. Intussusception in adults. Am J Surg 1954; 88: 32-43.
6. Felix EL, Cohen MH, Bernstein AD, Schwartz JH. Adult intussusception: Case report of recurrent intussesception and review of the literature. Am J Surg 1976; 131: 758-761.
7. Leape LL. Other disorders of the rectum and anus. In: Welch KJ, Randolph JG, Ravitch MM, O'Neill JA Jr., Rowe MI. eds. Pediatric Surgery. Chicago-London: Year Book Medical Publishers, 1986: 1038-1046.
8. Lewin KJ, Ranchod M, Dorfman RF. Lymphoma of gastrointestinal tract: A study of 117 cases presenting with gastrointestinal disease. Cancer 1978; 42: 693-707.
9. Ehrlich AN, Stalder G, Geller W, Sherlock P. Gastrointestinal manifestation of malignant lymphomas. Gastroenterology 1968; 54: 1115-1121.
10. Matsuchita M, Hajiro K, Kajiyama, Ohana M, Konishi Y, Kusumi F, et al. Malignant lymphoma in ileocecal region causing intussusception. J Gastroenterol 1994; 29: 203-207.