Intussusception in Pregnancy: A Rare Case Report

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Intussusception is a surgical emergency characterized by invagination of a segment of bowel into a distal portion. It leads to obstruction and compromise of mesenteric blood flow with resultant inflammation and the potential for ischemia of the bowel wall. It is very rare in pregnancy, and the high fetal and maternal mortality is due to a delay in diagnosis and treatment. We report a case of intussusception at a gestational age of 14 weeks and 6 days, when she presented with severe lower abdominal pain and vomiting. Diagnosis was confirmed by ultrasonography which revealed heteroechoic bowel in bowel appearance. Emergency laparotomy was done. Lead point was a submucosal lipoma at 60 cm from the ileocecal junction. Ileocecal intussusception reduction and segmental ileal resection and end-to-end anastomosis was done. The post-operative period was uneventful.

Keywords: Intussusception, Pregnancy, A surgical emergency

INTRODUCTION

Intussusception is the telescoping of proximal bowel wall into the lumen of the distal segment leading to obstruction and compromise of mesenteric blood flow which results in inflammation and the potential for ischemia of the bowel wall. It contributes to 1-5% of bowel obstructions in adults. Intussusception in pregnancy is very rare but potentially life-threatening. It is a challenge to both gynecologists and surgeons. Delay in diagnosis and management lead to significant maternal and fetal morbidity and even mortality. An accurate clinical diagnosis is difficult. Symptoms are mainly secondary to obstruction like nausea, vomiting, constipation, abdominal pain and a mass palpable in the abdomen. Surgical resection is almost always required. Here, we report a case of intussusception which caused abdominal pain in pregnancy, diagnosed by ultrasound and emergency surgery was done followed by an uneventful post-operative period for both mother and the fetus.

CASE REPORT

A 33-year-old second gravida with a history of previous caesarean section was admitted at a gestational age of 14 weeks and 6 days with acute onset of severe lower abdominal pain of 1 day duration. There was associated vomiting and history of constipation. She was afebrile, vital signs were normal and initial abdomen examination revealed tenderness in the lower abdomen with uterus palpable to 14 weeks size. A mass was detected in right iliac fossa on examination later on. Ultrasound revealed the heteroechoic bowel in bowel appearance in right hypochondrium with adjacent fluid filled bowel loops measuring 6.2 cm × 9.28 cm and diagnosis of ileocolic intussusception was made. Emergency surgery was done which revealed ileocecal intussusception with the lead point being a submucosal lipoma at 60 cm from ileocecal junction and 40 cm of ileum was within the ascending colon (Figure 1). Bowel congestion was present with reversible changes. Liver, spleen, stomach and other parts of the bowel were normal. Ileocecal intussusception reduction and segmental ileal resection anastomosis of the lead point was done, end-to-end in two layers (Figure 2). Post-operative period was uneventful. She was managed with analgesics, antibiotics and supportive measures. The pregnancy continued undisturbed. Histopathology report was ischemic necrosis of the small intestine with submucosal lipoma.

DISCUSSION

Intussusception is a rare cause of bowel obstruction characterized by invagination of a segment of bowel into a distal portion. The entering portion is termed the intussusceptum and the receiving portion the intussuscipiens. The intussusception carrying its blood vessels with it will finally undergo the changes consistent with a compromised blood supply and if neglected becomes gangrenous. The most common type is that of the invagination of ileum into caecum, with a peak incidence in babies under 1 year. In adults, it is usually due to the drag of a pedunculated tumor located in the intussusceptum, causing a telescoping of this segment into the intussuscipiens. Small bowel intussusception is more likely to have a benign lesion at the apex whereas ileocolic or colocolic are more likely

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The characteristic ultrasound findings are target sign and pseudokidney sign. Computed tomography or magnetic resonance imaging scan shows the bowel within bowel configuration, in which the layers of the bowel are duplicated forming concentric rings. Abdominal X-ray usually reveals features of obstruction. The type of surgery is dependent on the location of the lesion and the amount of bowel damage. Initial reduction followed by limited surgical resection is the preferred treatment in small bowel intussusception. A more careful approach is recommended in colonic intussusception because of a higher coexistence of malignancy. In late pregnancy, caesarean section should precede definitive bowel surgery. Even though it is a rare occurrence, obstetricians should be aware of the possibility of intussusception in pregnancy and the need for urgent and decisive intervention.

CONCLUSION

Intussusception in pregnancy is rare. However, all obstetricians should be aware of its possibility, since prompt diagnosis and treatment can markedly reduce the morbidity and even mortality. Ultrasound frequently confirms the diagnosis. Initial reduction and limited surgical resection is the treatment.

REFERENCES


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