Case 1
Case

- 34 Y female w/ history of splenomegaly and thrombocytopenia
- History of intermittent BRBPR and dark stools for 3-4 months; initial work up was planned (not really started)
- She developed acute onset abdominal pain and presented to the ED
- NAD, VS normal
- Her abd was distended but soft w/o guarding and splenomegaly on exam
- The pain resolved quickly after NGT was placed
Initial labs

- WBC 3, H/H = 11.7/36.3
- Platelet count = 57
- Lytes normal

- PMHx: basically negative
- PSHx: c-section x 2
Case: CT scan
Case: CT Scan

What are you thinking?
Possible diagnoses?
Plan?
Case: CT Scan Read

- Splenomegaly
- Possible portal HTN
- Small bowel intussusception
Case

What do you want to do?

• Double balloon enteroscopy
• Capsule endoscopy
• Diagnostic laparoscopy
• Laparotomy
• More imaging?
Case

Patient was actually admitted to the Medicine Service and they decided to get an MR enterography

Turned out to be very helpful...
MRE results

- Small bowel intussusception caused by 2.7 cm lead-point lipoma
- Splenomegaly
- Chronic portal venous thrombosis with stigmata of portal HTN
Our plan

- Anticoagulated with Lovenox
- She remained asymptomatic
- Plan: OR for diagnostic laparoscopy
  - ? Adhesions
  - Could direct incision location
Operation

- Took her to OR on HD 3
- Diagnostic laparoscopy
  - No adhesions
  - No other pathology
  - Small midline incision made right over area of intussusception
  - Delivered into wound
Intra-op
Operation

- Reduced intussusception
- Limited SB resection
- Stapled side-to-side anastomosis
6 cm incision
Intussusception:
the facts

- Asymptomatic intussusception (incidental finding on CT) rarely requires treatment
- Uncommon cause of adult bowel obstruction (<5%)
- Pathologic lead in up to 90% of symptomatic cases
  - Approximately 65% of colonic intussusception have a malignant lead point
  - In small bowel, up to 30% of lead points are malignant while the rest are benign:
    - polyps, Meckel diverticulum, strictures or benign neoplasms
- Up to 90% of symptomatic adult intussusception require definitive treatment with surgical resection
Intussusception: the facts

- Abdominal CT scan is considered the best diagnostic imaging modality
  - Accuracy of 60-100%
  - Classic finding is the “target sign” which is caused by bowel within bowel (A)
  - Mesenteric vessels within a bowel lumen may be seen as well (B)
Suspected malignancy

- Young woman, prior hx of gastric GIST
- Presented N/V and intussusception on CT
Intussusception: the facts

- Operate for (meaning an anatomic etiology):
  - Signs of gut ischemia (obviously)
  - Chronic symptoms
  - Intussusception resulting in bowel obstruction (symptomatic)
  - Palpable mass (high risk of cancer)
  - Anemia or GI bleeding (high risk of cancer)
  - Lead point or target sign on CT
  - Lesion length > 3.5cm on imaging
In the operating room----

• In select cases when a benign etiology has been firmly established (like this case), the intussusception may be “milked” out to limit the extent of bowel resection

• If unknown or hx of malignancy, then resect without reducing—resect en bloc
Intussusception
References

