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LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
Adult intussusception in two cases

İki olguda yetişkin intusepsiyonu

Tho the Editor,

Adult intussusception is usually diagnosed during surgery with the presence of mechanical obstructive syndrome (1, 2). Some patients may present with subacute or chronic form and might have undergone preoperative elective diagnostic tests.

Two female patients (64 and 60 years old) suffering from nonspecific abdominal pain and nausea for nearly two weeks had admitted to our emergency department, three months apart. Both patients had normal vital findings. There was significant abdominal distention and sensitivity was noticed on all quadrants, but there was no rebound or defense during physical examination. Rectal examination was normal. Routine hematologic values were normal except for mild leukocytosis. There was a sign of small bowel obstruction on the direct graphy.

The first patient had occult positive stool. Ultrasonography showed minimal fluid in abdomen, uncertain mass at the right lower quadrant and dilated small bowels. Laparotomy was planned with prediagnosis of late organ perforation, late perforated appendicitis or mesenteric vascular disease. During laparatomy, serohemorrhagic fluid was aspirated. Further observation showed ileocecal invagination. Because of the perforation risk and the probability of malignancy, we avoided reduction. Right hemicolectomy was performed including the invaginated ileum. When the operation material was examined, no lesion was noticed which could cause invagination; pathologic examination revealed transmural infarct at terminal ileum and cecum.

The second patient had a Pfannenstiel incision at cesarean section. Ultrasonography showed dilated small bowels, but optimal observation was not possible because of obesity. Our prediagnosis was strangulated small bowel obstruction, perhaps caused by an adhesion, and laparotomy was planned. During laparotomy, reactional fluid and dilated small bowels were observed. Further exploration revealed jejunojejunal invagination, which caused an obstruction about 100 cm distal of the Treitz ligament. Small bowel edema was noticed around this region. Because of the perforation risk, reduction was avoided. Segmental small bowel resection was performed. When operation material was examined, a pediculated polypoid lesion causing invagination was noticed. Immunohistochemical studies revealed submucosal originated myxoid liposarcoma.

The diagnosis of intussusception is difficult in adults. The majority of adult patients have a history of prior episodes of intermittent abdominal pain (71%), nausea and vomiting (68%), abdominal distention (45%) and tenderness (60%) consistent with partial obstruction (1). Abdominal plain films may be useful in evaluating severity of intussusception when obstructive symptoms occur.

Ultrasonography (US) is very appropriate and useful in the diagnosis of intussusception. First, it is a more available and generalized technique than computed tomography (CT), enabling it to be used more often with emergency and acute symptoms, and thus it is available at times of abdominal crisis in intermittent processes. Although CT scan of abdomen and pelvis with oral and intravenous contrast has been shown to be the most accurate diagnostic tool for evaluation of intussusception, in the hands of an experienced radiologist, US has a similar sensitivity and specificity to that

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of CT. Moreover, it allows a study on all planes and in real time, which is important since invagination is often a dynamic phenomenon (3, 4, 5).

In adults, an organic lesion is found within intussusception in over 90% of cases. The etiology is malignant in at least 40% to 50% of the cases (6, 7). Treatment usually involves laparotomy and resection of the affected segment.

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