Prolapsed intussusception

INTRODUCTION

Invagination is 2-4/1000 children. Prolapsed intussusception is invagination of an intestinal segment into the adjacent segment to it with exteriorization of the head of the intussusception through the anus. It is also known as Transanal Protrusion of Intussusception (TAPI). It is rare condition with high percent of misdiagnosis which determines late surgical procedure and adequate prognosis (Ndoin et al., 2005).

CASE PRESENTATION

A 9 month old girl weighting 10 kg was admitted in the Department of Pediatric Surgery presented with hemorrhage and protruding mass from the anus for 2 h. She had intermittent abdominal crisis but no abdominal distention or vomiting. There was no disease history prior to onset of symptoms. At admission, the child was pale and severely dehydrated. Her vital signs were: tachycardia 120/min, respiratory rate of 30/min, temperature of 37.5°C and delayed skin pinch of more than 3 s. The abdomen was scaphoid, tender with no palpable masses and bowel sounds were heard.

Digital rectal examination revealed an oedematous bowel protruding 2 cm from the anal verge. It was possible to rim around the prolapsed bowel (Figure 1). Systemic examination was normal. Laboratory investigation: blood count: leukocytosis 26.9*10^9; hemoglobin level 12.4 g/dl; hematocrit 35%; thrombocytes 274*10^9; electrolytes: sodium 140 mmol/L; potassium 4.3 mmol/L; creatinine 38 mmol/L; total protein 49.8 g/L; albumin 33.5 g/L; blood sugar 6.94 mmol/L and gas analysis showed a pH of 7.35; SGOT 58.2 mmol/L and SGPT 33.5 mmol/L. Urine analysis: sediment 6 to 7 leucocytes showed a lot of red blood and epithelial cells. X-ray examination of abdomen showed small intestinal obstruction.

The intussusception was recognized by clinical signs. We started fluids, electrolyte replacement and broad spectrum antibiotics. We inserted a nasogastric tube for decompression and did emergency procedure after hydrating the child. We found an ileocolic intussusception involving most of the small intestines (Figure 2). By laparotomy, we did ileocolic resection and ileorectal anastomosis (Figure 3).

The child was admitted to critical care unit for 2 days and initiated on total parenteral nutrition for 5 days post-operatively. The child was discharged healthy on the 7th day of admission. Vascular congestion with ulcerations were found on histological investigation (Figures 4 and 5).

DISCUSSION

Intussusception is a medical condition in which a part of the intestine folds into the section next to it. It typically involves the small bowel and less commonly the large bowel (Irene et al., 2018). Trans Anal Protrusion of Intussusceptions (TAPI) is a condition of intussusception that requires prompt diagnosis and treatment to lower mortality (Irene et al., 2018). For a period of 5 years (from 2013 to 2018) 15 children were admitted with diagnosis of ileocecal intussusception in our Department. The average age was 14.6 month (from 3 months to 5 years). Diagnosis was made by clinical examination, abdominal ultrasound,
Figure 1: Digital rectal examination revealed an oedematous bowel protruding 2 cm from the anal verge.

Figure 2: Ileocolic intussusception involving most of the small intestines.
abdominal X-ray and air-contrast enema and routine laboratory tests.

In patients presented in less than 48 h conservative treatments with air enema reduction was attempted.
CONCLUSIONS

Intussusception may become a life-threatening condition if not early recognized and treated. Management strategy is based on several major constellations - etiology of intussusception, patient’s general condition, time from onset to diagnosis, presence of intestinal necrosis. Proper fluid and electrolytes replacement therapy before surgery is essential to improve outcome. When delay from onset to diagnosis is more than 48 h, surgical treatment is indicated.

REFERENCES


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