



A pilot study over abdominal pain in jejuno-jejunal intussusception

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ABOUT THE STUDY

Abdominal pain is a common presentation to the Emergency Department (ED), with a wide range of differential diagnoses. Intussusception is more common in children, accounting for only 5% of cases reported in adults. Adult intussusception is caused by a well-defined lesion those results in a lead point, whereas most cases in children are idiopathic. Adult intussusception is also more commonly associated with cancer than childhood intussusception. Malignancy is more common in adults with large bowel intussusception than with small bowel intussusception.

Adult intussusception in the ED requires a high index of suspicion due to its variable presentation and often indolent course. Adult intussusception has been reported at various ages, with the highest prevalence seen in the 30-50 age groups. The male to female incidence ratio is roughly 2:1. When compared to children, malignancy is associated with intussusception in up to 42%-65% of adults.

The most common symptom is abdominal pain, which is reported in more than 70% of cases. The onset is gradual, with an average interval of around 5 weeks between onset and presentation, ranging from 1 day to 1 year. Pre-operative bowel obstruction is diagnosed in roughly half of all cases.

Patients with small bowel involvement typically present with colicky central abdominal pain and vomiting. In 40%-60% of cases, nausea and vomiting are also reported.

Diarrhea is common in large bowel intussusception and has been linked to lower abdominal pain and blood/mucus in the stool in 2%-29% of cases.

Adult intussusception has been classified in a variety of ways. Dean's 1956 classification, which describes four

types based on location, is still widely used. The most common type in adults is enteric intussusception, which begins in the small bowel. The ileocecal valve becomes the lead point in ileocecal intussusception. The ileum passes through the ileocecal valve in ileocolic intussusception. The colon telescopes in a contiguous section of the colon in colocolic intussusception.

Malignancy is more commonly associated with large bowel intussusception, accounting for up to 80% of cases, with adenocarcinoma being the most common malignant lesion seen. Lymphoma, lymphoma sarcoma, and leiomyosarcoma are examples of malignant lesions. The remaining lesions are benign, such as leiomyoma, endometriosis, and anastomosis. The majority of lead points in small bowel intussusception, on the other hand, are benign in nature, such as lipomas, polyps, hemangiomas, Meckel's diverticulum, lymphoid hyperplasia, and appendix villous adenoma. Malignancy is seen in only 14%-47% of cases of small bowel intussusception.

Laboratory tests are ineffective in determining the cause of intussusception. When patients present with abdominal pain and vomiting, the first imaging requested is often a plain abdominal X-ray, which has a low sensitivity to rule out bowel obstruction or intussusception.

Contrary to children, adults with suspected intussusception rarely undergo contrast enema studies. Ultrasound has been used more frequently in children than in adults to evaluate intussusception, and with a skilled operator has a high sensitivity and specificity approaching 100% for intussusception in children. This is not the case in adults. Because of increased accessibility and advancements in Computerized Tomography (CT) technology, this is the imaging modality most commonly used to diagnose intussusception. The majority of cases are discovered by chance during a CT scan for non-specific abdominal pain or bowel obstruction. This

modality can also provide additional information about bowel viability and etiology. On CT, various manifestations of intussusception are described, but the presence of a 'bowel-within-bowel' appearance is pathognomonic. When the beam is 90 degrees to the long axis of the intussusception segment, a target-like lesion is seen. This is characterized by a round shadow, intraluminal soft tissue, and eccentric fat density. When the beam is parallel to the long axis of the lesion, the intussusception can also appear as a sausage-shaped mass. When contrast is administered orally, the contrast coating of the intussusceptum's outer opposing walls can be seen. Reni form kidney-like appearance is also described. The accuracy of magnetic resonance imaging of the small bowel is comparable to that of CT. It does, however, require a stable patient to remain still for a longer period of time and may not be as readily available in the emergency department as CT.

Adult intussusception management remains a point of contention. In adults, well-designed therapeutic trials comparing surgical to non-surgical treatment are lacking. In contrast to children, most adult cases are managed surgically, possibly due to the increased likelihood of discovering a pathological lesion. According to some studies, small bowel intussusception can be reduced without resection if an underlying benign lead point is suspected, a medically treated condition such as inflammatory bowel disease is discovered, or the surgery could result in short bowel syndrome. A small bowel enteroscopy or capsule endoscopy is recommended in these cases to rule out an intraluminal lesion that may

predispose to recurrent intussusception. Bowel obstruction, a palpable abdominal mass or a lead point identified on imaging, gastro-intestinal bleeding, constitutional symptoms of malignancy, and colo-colic or ileo-colic intussusception due to their greater association with malignancy are all indications for surgical management of adult intussusception.

Another study found that surgery was used as a treatment modality in patients with clinical features of acute abdomen, clinical or radiological signs of bowel obstruction, peritonium, septic shock, intussusception with a mass visible on CT scan, and patients with a diagnosis of colonic or ileocolic intussusception (often associated with malignancy), even when there was no acute abdomen.

Adults with intussusception have a variable and non-specific presentation. The most common presenting feature is abdominal pain, which can often be gradual in onset.

The majority of diseases are discovered incidentally on contrast CT of the abdomen and pelvis or during surgery. When compared to children, adult intussusception is more commonly associated with a well-defined pathological lesion acting as a lead point, such as malignancy. Malignancy is more common in adults with large bowel intussusception than with small bowel intussusception. While there is no agreement on management, adult intussusception patients are more likely than children to require surgical intervention.