



## 9 cm Ileal Polyp "As a Bombshell"

Msheik A<sup>1\*</sup>, Younes F and Dbouk S<sup>3</sup>

<sup>1</sup>Department of Neurological Surgery, Lebanese University, Lebanon

<sup>2</sup>Department of General Surgery, Lebanese University, Lebanon

<sup>3</sup>Department of General Surgery, Al Zahraa Hospital UMC, Lebanon

### Abstract

Small intestinal polyps can manifest in a variety of ways and subtly, which frequently delays diagnosis. The presenting symptoms are determined by the location of the polyp. We represent the case of a young female patient who presented with signs of abdominal obstruction and was revealed to have an intussusception caused by an ileo-ileal polyp. The anatomical location affects how a polyp presents clinically. The diagnosis and customization of the medicinal and surgical treatments for the illness depend on vigilance and foresight of the onset of particular pathologies, despite their rarity.

### Introduction

An imbalance between cellular growth encouragement and cellular growth inhibition leads to gastrointestinal polyps and cancer. The deficiency is caused by either a growth-promoting protein that has been elevated by an active oncogene or by a growth-inhibiting protein that has lost its function, typically because of the inactivation of a tumor suppressor gene [1]. GI polyps can develop anywhere along the GI tract [1]. Even though the small bowel makes up 90% of the gastrointestinal tract's mucosal surface area, it only rarely develops neoplasia and represents less than 3% of all digestive tract cancers. Small intestinal neoplasms make up around 0.6% of all new cases of cancer each year in the US [1]. The United States also has the highest age-adjusted incidence of small bowel tumors in the entire world, which may be influenced by racial disparities [2]. Despite a clearly increasing incidence, the full prevalence of small intestinal neoplasms is largely concealed by diagnostic challenges. Given the ambiguous and varied symptoms of small intestine tumors as well as the difficulties of endoscopic and radiographic identification, this condition provides a special clinical challenge. Given the low prevalence, a diagnostic test must be precise and have a strong negative predictive value [1].

Small intestinal polyps can manifest in a variety of ways and subtly, which frequently delays diagnosis [3]. Many are still asymptomatic, and they are discovered through surgery in patients who have tiny bowel blockages or during autopsies. Abdominal pain, iron deficiency anemia or covert blood loss, weight loss, nausea and vomiting, and intermittent blockage are among the symptoms of small intestinal polyps, which are present in 40% to 70% of patients [3]. Malignant neoplasms are less likely to be asymptomatic than benign small intestinal polyps. Compared to malignant neoplasms, small bowel neoplasms are more likely to manifest with overt gastrointestinal hemorrhage when they are symptomatic. As opposed to benign small intestinal neoplasms, malignant small bowel neoplasms are more likely to present with weight loss and abdominal pain [1,4]. However, due to their variety, benign and malignant tumors cannot be distinguished solely based on clinical appearance. The presenting symptom may also be determined by location; for example, proximal duodenal lesions may cause jaundice because of obstruction of the distal common duct or stomach outlet (CBD) [3]. Small bowel lipomas frequently have intermittent intestinal blockage, which can be brought on by massive intraluminal neoplasms or intussusception.

We represent the case of a young female patient who presented with signs of abdominal obstruction and was revealed to have an intussusception caused by an ileo-ileal polyp.

### Case Presentation

We present the case of a 29-year-old female patient who was received at the Emergency Department (ED) with a three days history of persistent diffuse abdominal pain, several episodes of non-bilious, non-bloody vomiting, and obstipation. Upon presentation, the patient was afebrile (36.4 degrees), and tachycardic (146 beats per minute). She had a systolic blood pressure of 113 mmHg, diastolic blood pressure of 74 mmHg, and blood oxygen saturation of 97%.

### OPEN ACCESS

#### \*Correspondence:

Ali Msheik, Department of Neurological Surgery, Lebanese University, Hadath, Lebanon,

E-mail: [dr.alimsheik@gmail.com](mailto:dr.alimsheik@gmail.com)

Received Date: 15 Mar 2023

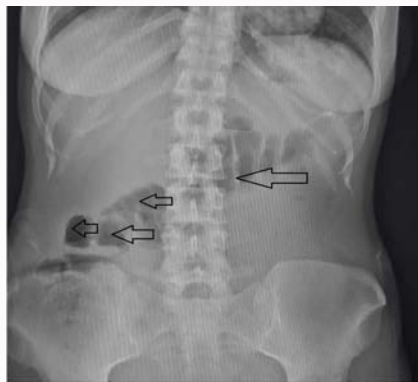
Accepted Date: 28 Mar 2023

Published Date: 01 Apr 2023

#### Citation:

Msheik A, Younes I, Dbouk S. 9 cm Ileal Polyp "As a Bombshell". *Clin Case Rep Int.* 2023; 7: 1519.

Copyright © 2023 Msheik A. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



**Figure 1:** Abdominal X-ray of the patient. Normal findings on abdominal X-ray (black arrows). Courtesy of Al Zahraa Hospital UMC, Beirut, Lebanon.



**Figure 2:** Operative Findings. A: Intraoperative image of the bowels showing the location of the intussusception; B: Size of the removed polyp.

The patient had no past medical history. However, she had a laparoscopic sleeve gastrectomy before 1 year, and an inguinal hernia repair 9 years before presentation. The abdomen was tympanic, diffusely tender, and distended. Auscultation revealed absent bowel sounds. A Nasogastric Tube (NG) was inserted, and 500 ml was drained within the first hour after insertion. An abdominal X-ray was taken (Figure 1).

Laboratory workup showed elevated C-Reactive Protein levels (CRP). The condition of the patient progressively deteriorated. The laboratory workup revealed an increasing white blood cell count of the blood (14000) with 89% neutrophils. An urgent laparotomy was done. The small bowel was distended and an intussuscepted loop was visualized (Figure 2A). Longitudinal enterotomy was done along the location of a palpable intraluminal mass. A 9 cm pedunculated polyp was found and resected (Figure 2B). The patient tolerated the procedure and was discharged 5 days after the surgery.

## Discussion

One hundred and fifteen years after the first documentation by Paul Barbet in Amsterdam, John Hunter defined intussusception as the telescoping of a proximal segment of the Gastrointestinal (GI) tract, into the lumen of the adjacent distal segment [4]. The intussusceptum goes into the intussuscipiens. In 1871, Jonathan Hutchinson was the first to operate on a child with intussusception [5]. Despite being the most common cause of constipation in children, intussusception represents only 5% of the constipation cases in adults, where it is due to a pathologic condition, namely

tumors, lymphomas, venous malformations or polyps, in 90% of the cases, 70% of which demand definitive surgical treatment [6]. While discrete colocolic intussusceptions represent 50% of the cases, 12% of the cases represent ileocolic and ileocecal intussusceptions. Enteric intussusceptions constitute the remaining 38% [6]. 46% of the cases of adult intussusception are associated with malignant neoplasia, and 29% are associated with benign processes such as adenomatous polyps, adenomas, and mucocoeles [7]. The remaining cases are attributed to idiopathic and congenital conditions. Obstruction post-Laparoscopic Roux-in Y Gastric Bypass (LRYGB) surgery is cryptic and is attributed to the formation of fibrous membranes of wounds, internal hernias, and retrograde intussusception in 0.1% to 0.3% of the cases only [7]. Roux stasis syndrome and the iatrogenic lead point creation by suture or staple lines at the anastomosis are suggested explanations [8]. Computed Tomography (CT) of the abdomen and pelvis is the most sensitive method to confirm this condition [8].

Aydin et al. and Marsicovetere et al. reviewed treatment modalities according to the location of the intussusception [9,10]. Right-sided colonic cases are treated by resection and primary anastomosis in a one-stage surgery. A two-stage surgery is reserved for left-sided colonic and rectosigmoid intussusceptions [11]. Enteric cases with benign etiology are considered with reduction and limited enterectomy.

## Conclusion

The anatomical location affects how a polyp clinically presents. The diagnosis and customization of the medicinal and surgical treatments for the illness depend on vigilance and foresight of the onset of particular pathologies, despite their rarity. We present the case of an ileo-ileal intussusception in an adult female patient which was precipitated by the presence of a large ileal polyp. Surgical Intervention was mandatory.

## References

1. Testa U, Pelosi E, Castelli G. Colorectal cancer: Genetic abnormalities, tumor progression, tumor heterogeneity, clonal evolution and tumor-initiating cells. *Med Sci (Basel)*. 2018;13:31.
2. Larsen Haidle J, MacFarland SP, Howe JR. Juvenile Polyposis Syndrome. University of Washington, Seattle. 2003.
3. Dahlerup JF, Eivindson M, Jacobsen BA, Jensen NM, Jørgensen SP, Laursen SB, et al. Diagnosis and treatment of unexplained anemia with iron deficiency without overt bleeding. *Dan Med J*. 2015;62.
4. de Moulin D. Paul Barbet, M.D.: A seventeenth-century Amsterdam author of best-selling textbooks. *Bull Hist Med*. 1985;59:506-14.
5. Marinis A, Yiallourou A, Samanides L, Dafnios N, Anastasopoulos G, Vassiliou I, et al. Intussusception of the bowel in adults: A review. *World J Gastroenterol*. 2009;28:407-11.
6. Zhang KS, Bansal J, Bansal A, Chitnavis V. Adult intestinal intussusception caused by the gastrojejunostomy tube: An endoscopically treatable phenomenon. *Case Rep Gastrointest Med*. 2021;2021.
7. Su T, He L, Zhou T, Wu M, Guo Y, Wang Q, et al. Most adult intussusceptions are caused by tumors: A single-centre analysis. *Cancer Manag Res*. 2020;12:10011-15.
8. Boudourakis LD, Divino C, Nguyen S. Retrograde intussusception seven years after a laparoscopic Roux-en-Y gastric bypass. *J Minim Access Surg*. 2013;9:82-3.
9. Aydin N, Roth A, Misra S. Surgical versus conservative management of adult intussusception: Case series and review. *Int J Surg Case Rep*. 2016;20:142-6.

10. Marsicovetere P, Ivatury SJ, White B, Holubar SD. Intestinal intussusception: Etiology, diagnosis, and treatment. *Clin Colon Rectal Surg.* 2017;30:30-39.
11. Grundmann RT. Primary colon resection or Hartmann's procedure in malignant left-sided large bowel obstruction? The use of stents as a bridge to surgery. *World J Gastrointest Surg.* 2013;5:1-4.