

SPONTANEOUS JEJUNAL INTUSSUSCEPTION AFTER OPEN RADICAL NEPHRECTOMY

RAJVEER S. PUROHIT, BENJAMIN M. YEH, AND MAXWELL V. MENG

Adult bowel intussusception is distinctly uncommon and most often due to a primary abnormality of the bowel serving as the nidus.¹ We illustrate a case of spontaneous jejunal intussusception developing shortly after transperitoneal nephrectomy, highlighting the importance of considering this rare etiology in the urologic patient.²⁻⁵

Uncomplicated right radical nephrectomy and level II caval thrombectomy was performed through an abdominal incision. Examination of the bowel did not reveal extrinsic abnormalities or herniations. His diet was advanced after flatus (day 5). However, he had sporadic emesis and radiographic findings consistent with ileus. Suspicion of an obstructive cause of persistent nausea led to computed tomography (Fig. 1). Observation was continued (10 days) with minimal abdominal pain and flatus, but occasional emesis. Owing to a lack of clinical or radiographic resolution, he underwent laparotomy and resection of the intussusception (Fig. 2).

Limited data are available regarding the optimal management of idiopathic adult intussusception. Traditionally, the likely presence of an underlying etiology (eg, lipoma, tumor), potential for bowel ischemia, and mortality (up to 29%) argued for early surgery. Unenhanced computed tomography

may characterize the degree of vascular compromise and predict the need and urgency for surgery.⁶ A review of 37 cases of adult small-bowel intussusception found conservative management successful in 84% of patients; the length of the intussusception (3.5 cm) was the only factor associated with the outcome and need for surgery.⁷ In our patient, early identification of the intussusception, a stable clinical situation, and the known absence of a bowel lesion permitted observation before intervention.

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From the Department of Urology, State University of New York Downstate Medical School, Brooklyn, New York; and Departments of Radiology and Urology, University of California, San Francisco, School of Medicine, San Francisco, California

Reprint requests: Maxwell V. Meng, M.D., Department of Urology, University of California, San Francisco, School of Medicine, San Francisco, CA 94143-0738. E-mail: mmeng@urol.ucsf.edu

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B



C

FIGURE 1. (A) Axial computed tomography scan demonstrating area of intussusception, appearing as classic “target” or “bull’s eye” lesion (arrow).⁸ Area extended for 10 cm, with proximal dilation of small bowel. Progressive bowel edema may obscure this finding on delayed imaging. Findings predicting vascular compromise include (a) hypodense layer in middle of, (b) fluid collection in space surrounded by, or (c) gas collection in space surrounded by returning wall of intussusceptum.⁶ (B) Additional image showing bowel mesentery of intussuscepted segment and entering vessels (arrow). (C) Oblique coronal reformation demonstrating intussusception (arrow) and oral contrast around it.

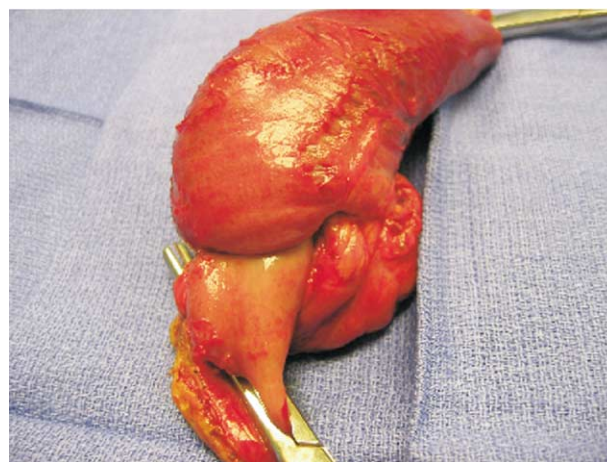


FIGURE 2. Gross appearance of resected segment of jejunal intussusception. Pathologic examination revealed serosal adhesions, fibrosis, and focal foreign body reaction, without carcinoma.