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FEATURES OF INTESTINAL INTUSSUSCEPTION IN ADULTS. A CLINICAL CASE

Rayimov G.N.1,
Toychiyev I.K.1,
N. A. Salokhiddinov2
B. T. Khasanov2,
Kholmatov K.K.2,
Tillaboldiyev A.R.2
1-Ferghana Medical Institute of Public Health
2-Ferghana branch of the Republican Scientific Center of Emergency Medical Care

Resume
The article presents a clinical case of a 37-year-old patient who was admitted to the hospital with signs of intestinal obstruction. During the diagnostic process, the cause of the obstruction was promptly detected - intestinal intussusception, which allowed avoiding complications in the form of intestinal necrosis, with the subsequent development of perforation and peritonitis. The proposed diagnostic and therapeutic algorithm justifies patients with intestinal intussusception, which improves the clinical outcome and reduces the risk of intra- and postoperative complications.

Keywords. Intestinal intussusception, clinical case, intestinal obstruction.

Introduction

Intussusception is the insertion of the proximal segment of the intestine into the lumen of the adjacent distal segment. From the time of the first description of intestinal intussusceptionиin 1674 to the present day, this pathology is attributed to diseases of early childhood. However, intussusception also occurs in adults with a frequency of approximately 2-3 in 1,000,000 per year, causing no more than 1% of all cases of intestinal obstruction. While infantile intussusception is considered idiopathic in 90% of children, a mechanical cause in adults can be detected in more than 90% of cases. Due to the rare prevalence of this pathology and non-specific symptoms, diagnosis is difficult, which leads to a large number of diagnostic errors. Radiography of the abdominal organs is the first diagnostic tool that is used in the presence of symptoms of intestinal obstruction, which in most cases predominate in the clinical picture. Nevertheless, due to its high sensitivity and specificity, ultrasound of the abdominal cavity is a valuable diagnostic tool that complements X-ray research methods. However, due to its higher sensitivity, CT is the most accurate imaging method for diagnosing intestinal intussusception and may be superior to the aforementioned studies. In developing countries where access to imaging techniques such as CT and endoscopy is a challenge, a timely diagnosis should be made based on a medical history and clinical examination. The clinical picture includes abdominal pain, nausea and vomiting, as well as melena. The final diagnosis is made during the operation. If the laparotomy was not performed in a timely manner, a fatal

outcome cannot be avoided. Recently, laparoscopy has gained popularity as a minimally invasive procedure for the diagnosis and treatment of intussusception in adults. The laparoscopic approach is associated with low mortality and short hospital stays, and is therefore the preferred technique for treating intussusception in adults. We observed a rare case of intestinal intussusception in adults.

Description of the clinical case

A patient born in 1984, who was admitted on 12.04.2020 to the Emergency Abdominal Surgical Department of the Ferghana branch of the RSCEMP in an emergency order with complaints of epigastric and parotid pain, nausea, vomiting with "bile", general weakness. From the medical history, it is known that he was ill for16hours before admission, was not treated independently, and did not seek help. Surgical interventions on the abdominal organs were not tolerated. Objectively: general condition of moderate severity. A / D 110/70 mmHg, temperature 36.8°C, heart rate 87 beats / min. The skin and visible mucous membranes are pale pink in color. In the lungs-vesicular breathing, no wheezing. The heart sounds are muted, rhythmic. The tongue is dry, covered with a white-yellow coating. The abdomen is rounded, participates in the act of breathing, symmetrical, swollen due to the upper parts, soft on palpation, moderately painful in epigastric region, without peritoneal symptoms, in the parotid region there is not a pronounced symptom of "splashing noise". Dulling of the tympanic sound: in the sloping places of the abdomen was not detected. Auscultation: intestinal peristalsis is heard. Gases escape. During rectal examination, the perianal area is without features, there are fecal masses in the lumen of the rectum. Urination is free and painless. Diuresis is normal. Admission tests: Total blood count: Hb-145g / l, red blood cells-4.7 x^{10-12}/l, white blood cells-6.8 x^{109}/l, ESR – 11 mm/h. Clinical analysis of urine: color yellow, transparent, no protein detected, transitional epithelium-in small amounts, white blood cells-3-4 in the subcutaneous space. Biochemical blood analysis: total protein-68 g / l, glucose-4.4 mmol/l, urea-4.7 mmol/L, creatinine-86.7 nmol/L, AlT-22 U/l, AsT-36 U/ L, total protein-12.6 nmol/L, amylase-83 U/lL. On the X-ray survey of the abdominal organs: distention of the jejunum loops with a horizontal fluid level. Along the course of the colon – gas. Ultrasound of the abdominal cavity, kidneys and pelvic organs: the liver does not protrude from under the costal arch, the tissue is of normal echogenicity, the structure is uniform. W / p – 68 x 30 mm, the shape is correct, the walls are sealed. The pancreas is not located due to hyperpneumatosis of the small intestine. There is not a large amount of fluid between the intestinal loops. According to CT scans of the abdominal organs, the loops of the small intestine (at the level of the jejunum) are significantly expanded to 48 mm, with the presence of horizontal fluid levels. At the border of meso-and hypogastrium to the left of the midline, a sharp narrowing of the small intestine with a diameter of up to 12 mm is determined, and at this level the loop of the small intestine is ring-shaped, with an inhomogeneous structure. There is a moderate severity of adjacent fiber at this level. The terminal parts of the ileum are not dilated, up to 13 mm in diameter. There is a small amount of fluid in the vesico-rectal space. Multiple mesenteric lymph nodes are visualized up to 10 mm in size, few, retroperitoneal paraaortic – up to 6-7 mm. Taking into account the complaints, medical history and research results, the diagnosis was established: "Inversion of the small

intestine. Acute high small bowel obstruction." To clarify the diagnosis and determine the tactics of surgical treatment, a decision was made to perform diagnostic laparoscopy. During the revision of the abdominal cavity, the inter-loop is determined a small amount of light liquid; the jejunum loops are sharply swollen up to 5 cm in diameter for 25 cm. from the Treitz ligament, where invagination of the small intestine is determined, distally-the intestine is in a dormant state; attempts to disinvaginate are unsuccessful; a decision has been made to convert. A median-medial laparotomy was performed, the small intestine was removed into the wound with intussusception by deinvagination on the mesenteric, and during disinvagination, a dense tumor of 4 x 2 x 1 cm in size was revealed on the mesenteric margin, almost completely narrowing the lumen of the intestine. Mesentery of the small intestine in the area of the cystic tumor contains multiple lymph nodes up to 0.7-1 cm. Also, enlarged paraaortic lymph nodes and along the course of the superior mesenteric artery up to 0.6 – 0.8 cm are determined. The pulsation of the mesentery vessels of the small intestine is satisfactory. Considering the close location of the tumor from the Treitz ligament, mobilization of the small intestine distal by 10 cm and proximal by 10 cm was performed, with resection of 20 cm of the jejunum and the formation of an inter-intestinal anastomosis "side - to-side".

Macro-preparation: a resected fragment of the jejunum 20 cm long, in the lumen of which a tumor-like formation with dimensions of 3.5 x 2 cm is determined, completely narrowing the lumen, of a cartilaginous consistency, on a white incision sprouting the intestinal wall to the serous membrane, the mesentery is not affected.

Micro-preparation: the tumor is presented with normal and hyperchromic nuclei, with the presence of atypical mitoses. The stroma of the neoplasm is weakly expressed, unevenly infiltrated by lymphocytes and plasmocytes. There is an invasion of tumor tissue in the muscle layer of the intestinal wall. No tumor tissue was detected along the proximal and distal borders of the bowel resection. There are reactive changes in the lymph nodes. Conclusion: Adenocarcinoma of the small intestine of moderate differentiation with invasion into the muscle layer of the small intestine. The postoperative period was smooth. The patient was discharged from the hospital on the 7th day of the postoperative period in a satisfactory condition. Final diagnosis: "Adenocarcinoma of the ileum T3N0M0. Acute intussusceptible small bowel obstruction".

Used Literature

1. Гафтон Г.И., Щербаков А.М., Егоренков В.В., Гельфонд В.М. Нарушение проходимости желудочно-кишечного тракта. //Практич. онкология. Ургентные состояния в онкологии.- 2006.- т.7.- №2.- с. 77-83.Абрамов, А.Ю. Острая тонкокишечная непроходимость опухолевой природы / А.Ю. Абрамов, А.Б. Ларичев, Н.В. Борисова // Вестник экспериментальной и клинической хирургии. - 2011. Т. IV, № 3. - С. 592 - 595.
2. Абдулаев М.А. Выбор хирургической тактики при острых осложнениях рака ободочной кишки. Автореф. дисс. . докт. мед. наук. Санкт-Петербург, 2004.- 45 с.

3. Ан В.К., Ривкин В.Л. Неотложная проктология. М.: ИД Медпрактика-М, 2003.- 144 с..
4. Бондарь Г.В., Башеев В.Х., Псарас Г.Г., Золотухин С.Э., Бондаренко Н.В. Хирургическое лечение рака толстой кишки, осложненного полной кишечной непроходимостью. //Онкохирургия.- 2008.- №1.- с. 23.
5. Дронов, А.Ф. «Лапароскопия в диагностике и лечении кишечной инвагинации» / А.Ф. Дронов, И.В. Поддубный // Детская хирургия. - 2000. №6. - С. 33-38.
6. Морозов, Д.А. Эффективность пневматической дезинвагинации на основании анализа лечения 1000 больных / Д.А. Морозов, С.Ю. Городков, Ю.В. Филиппов и др. // Медицинский вестник Северного Кавказа. - 2009. - № 1. - С. 43.
7. Макаров, П.А. Рациональная лечебно-диагностическая тактика при инвагинации кишечника / П.А. Макаров, В.И. Чукреев, В.Н. Сорокина и др. // Медицинский вестник Северного Кавказа. - 2009. - № 1. - С. 41.
8. Канделис Б.Л. Неотложная проктология. Руководство для врачей. Л.: "Медицина", 1980.- 272 с.