Intestinal Intussusception in an Adults Due To Meckel’s Diverticulum: a Case Report

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Intussusceptions due to an inverted Meckel’s diverticulum are considered as a rare condition. We present a case of an 83 year-old male with intestinal obstruction due to an inverted Meckel’s diverticulum at the base of ileoileal intussusceptions. Ileal strangulation may occur due to intussusception of a Meckel’s diverticulum. Hence the clinician should be aware of this possibility and diagnose more quickly to avoid unnecessary bowel resection.

Key Words: Intussusceptions, Meckel’s Diverticulum, Obstruction, Adult

CASE REPORT

A 83 year old male presented with 48 hour history of abdominal pain, nausea and vomiting. On his physical examination there were abdominal tenderness, rebound and increased bowel sounds. Rectal examination was normal with a negative hemacult test stool. Abdominal computed tomography showed the characteristic target lesion in the left lower quadrant, indicating an intussusception.

During the operation, patient was found to have an ileoileal intussusception due to Meckel’s diverticulum (Fig.1,2). The intussusception was reduced manually. Partial resection of the ileum and end to end anastomosis was performed.

Medical therapy was prescribed due to pulmonary infection for 10 days. Except the chest infection, post-operative course was uneventful and the patient was discharged on the post-operative day 16.

DISCUSSION

The nature of the invagination varies greatly. In small intestine there is a predominance of benign processes and a 90% of them include polyp, tuberculosis, inverted Meckel’s diverticulum and adhesions. In the present case the
cause of intussusception was Meckel’s diverticulum.

**Figure 1.** At the operation ileoileal intussusception was seen.

The diagnosis of intussusception in adults can be difficult preoperatively. In adults one of the most important complications is small bowel obstruction. In our case, small bowel obstruction was present on plain abdominal graphy as the previous reported cases. Ultrasonography has been used to evaluate suspected intussusception in adults. On CT, an intussusception appears as a ‘target lesion’ bowel within bowel with or without contained fat and mesenteric vessels. In our case CT was performed and CT confirmed diagnosis. It therefore appears that the CT scan is very useful and simplifies making the diagnosis. The optimal treatment of adult intussusception is not universally agreed open. All authors agree that laparotomy is mandatory, in view of the likelihood of identifying a pathologic lesion. Most authors recommend a segmental small bowel resection of the invaginated part as surgical treatment of the intussusception. In case of intussusception due to Meckel’s diverticulum surgical treatment choice should be resection of a small bowel including Meckel’s diverticulum. In the present case, Meckel’s diverticulum should be resected together with a small segment of ileum as in literature. In conclusion, intussusceptions of a Meckel’s diverticulum might cause ileal strangulation because of acute obstruction. The clinician should be aware of this possibility and diagnose more quickly to avoid unnecessary bowel resection. In cases of early and unstrangulated patients a wedge resection of diverticulum will be appropriate.

**REFERENCES**


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