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Gastrointestinal

Small bowel intussusception in 2 adults caused by inflammatory polyps

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ABSTRACT

Inflammatory fibroid polyps are rare, benign pseudotumors of the gastrointestinal tract of unknown etiology, which may rarely present as bowel intussusception and obstruction. The authors describe the clinical, radiologic, and pathologic features of 2 patients with ileal inflammatory fibroid polyps presenting as small bowel intussusception.

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Introduction

Inflammatory fibroid polyp (IFP) is a rare lesion of the gastrointestinal (GI) tract first described by Vanek in 1949 [1]. Although they may occur in any part of the GI tract, they are most commonly located in the stomach [2,3]. The pathogenesis of IFPs is largely unknown [3]. These lesions encompass a known, albeit rare, cause of small bowel intussusception [4,5]. We describe the clinical, radiologic, and pathologic features of 2 cases of IFPs presenting as small bowel intussusception.

Case 1

A 41-year-old woman presented to the emergency department of our institution with mild colicky lower abdominal pain lasting for less than 6 hours. She referred 1 episode of vomiting and loose stools. Her medical history was unremarkable except for an upper respiratory tract infection treated with one course of antibiotics (amoxicillin/clavulanate) 1 week before presentation. Physical examination revealed a nontender, soft abdomen, with mild pain on deep palpation of the lower

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Fig. 1 – Abdominal erect anteroposterior radiograph shows fecal distention of the left colon and normal bowel gas pattern in the right colon. No radiographic signs of intestinal obstruction or pneumoperitoneum are present.

quadrants. There were no signs of peritoneal irritation. Vital signs were within normal limits (blood pressure 140/72 mm Hg, heart rate 69 per minute, 100% O₂ saturation), and her temperature was normal (35.5°C).

Laboratory tests revealed mild microcytic anemia (11.3 g/dL; mean corpuscular volume [MCV] 84.1 fL) and slight hypokalemia (3.3 mEq/L). No leukocytosis was noted (white blood cell [WBC] $8.7 \times 10^9/L$). C-reactive protein measurement was not performed.

An erect abdominal radiograph was performed (Fig. 1), which showed fecal distention of the descending colon, but no other significant abnormalities were present.

The patient underwent abdominal ultrasound examination (images not available), which was positive for small bowel intussusception in the hypogastrium. Computed tomography (CT) evaluation (Fig. 2) confirmed an ileoileal intussusception in the lower abdomen. Although no unequivocal endoluminal lesions were noted, a 35-mm-long slight bowel wall thickening was reported. There was no ascites, and no signs of intestinal obstruction were observed.

Exploratory abdominal laparoscopy was performed, confirming the imaging findings. Segmental enterectomy was performed. There were no surgery-related complications, and the patient was discharged 4 days later.

The surgical specimen consisted of a 24-cm-long small intestine segment with hemorrhagic ischemic lesions. In the mucosa, a 48-mm polypoid lesion with smooth surface was present (Fig. 3).

Histologic examination (Fig. 4) revealed a polypoid lesion with superficial interstitial hemorrhage and ischemic lesions. A moderate inflammatory infiltrate was also present. Immunohistochemical study was positive for focal CD34 expression in stromal cells. The final pathologic diagnosis was IFP.

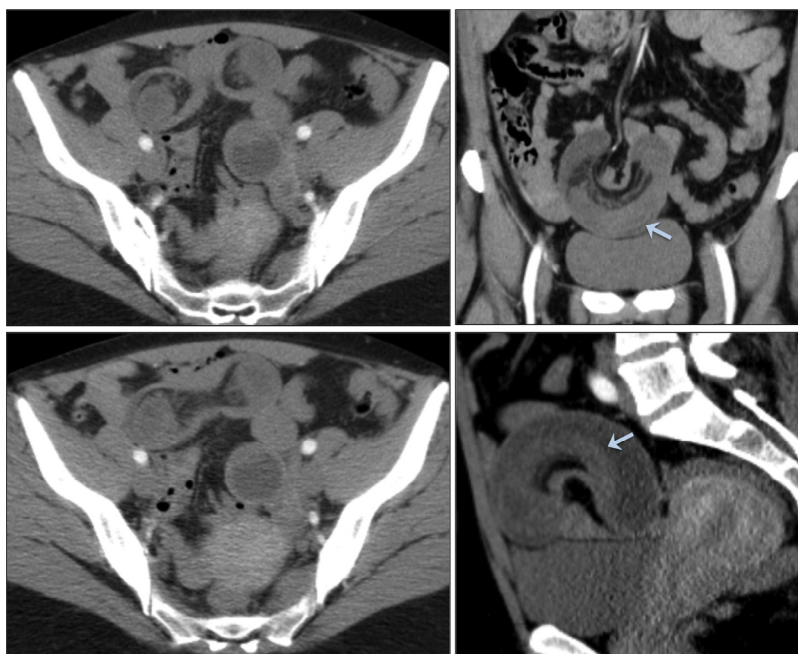


Fig. 2 – Contrast-enhanced computed tomography (CT) scan of the abdomen and pelvis. Contiguous axial images (left panel) confirm typical bowel-in-bowel appearance of intussusception. Coronal and sagittal views (right panel) depict slight bowel wall thickening (arrows). No free peritoneal fluid, lymphadenopathy, liver metastasis, or evidence of bowel obstruction was noted.

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