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Adult ileocolic intussusception due to primary diffuse large B-cell lymphoma

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CASE REPORT

A 44-year-old male patient presented to the Emergency Department complaining of sudden onset cramping abdominal pain associated with nausea and vomiting. The physical examination revealed abdominal distention, but no signs of peritoneal irritation. A computed tomography (CT) of the abdomen identified the presence of ileocecal intussusception (Fig. 1). Soon after admission, the patient experienced complete improvement of the symptoms. The abdominal CT scan was repeated after 24 hours, and the intestinal intussusception was no longer visualized. The patient was then discharged, and an outpatient colonoscopy was scheduled. During the following days, the subject remained asymptomatic. Nevertheless, the colonoscopic examination indicated the re-occurrence of ileocecal intussusception, without any noticeable mucosal changes (Fig. 2). Thereafter, a video-laparoscopy was performed, the invagination was reduced and a 3 cm

tumor mass was identified in the terminal ileum wall. The pathologic bowel segment was resected *en bloc* using oncologic principles. The excised tissue specimen (Fig. 3) was sent for histopathological analysis, which showed an atypical lymphocytic infiltrate suggestive of non-Hodgkin lymphoma. Immunohistochemistry confirmed the diagnosis of diffuse large B-cell peripheral non-Hodgkin lymphoma, of the germinal center B-cell-like (GCB) subtype. The patient was referred to Clinical Oncology for further management and care.

DISCUSSION

Intestinal intussusception in adults is typically due to pathologic lead point. As opposed to the pediatric population, approximately 90 % of the adult cases have an identifiable etiology (2) and approximately 50 % of adult cases are accompanied by malignant lesions (2). The most commonly reported symptoms include abdominal pain and intestinal obstruction (3). In this report, the patient experienced complete symptoms and tomographic resolution. High suspicion is essential to ensure a correct diagnosis and effective treatment of the underlying condition.

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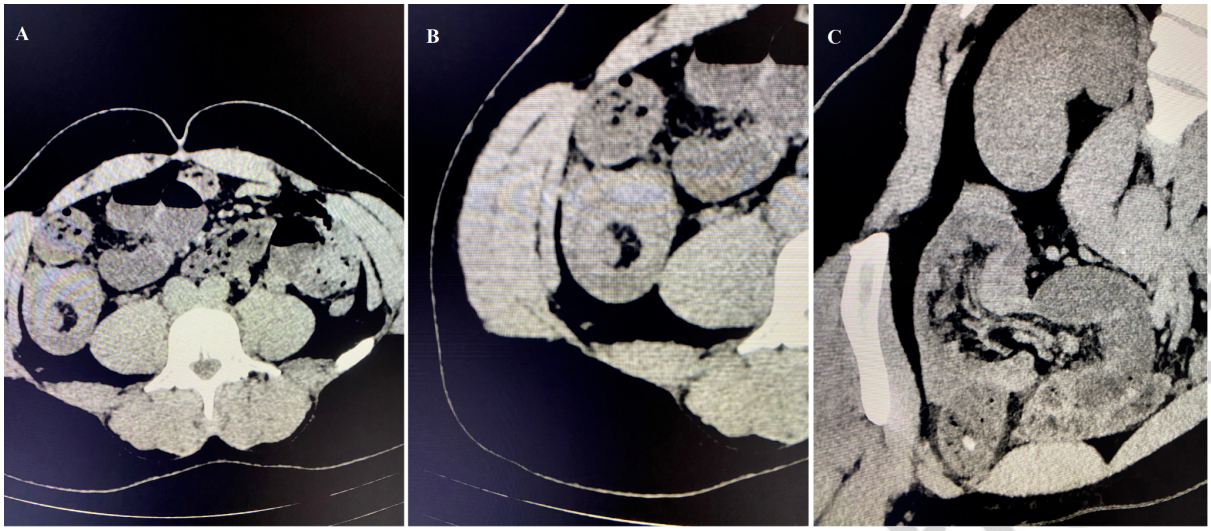

Fig. 1. Computed tomography cross-section images showing ileocecal intussusception. A. Axial image section characteristic of intussusception (target sign). B. Detail (target sign). C. Coronal-oblique reconstruction image, showing the mesentery within the ascending colon.

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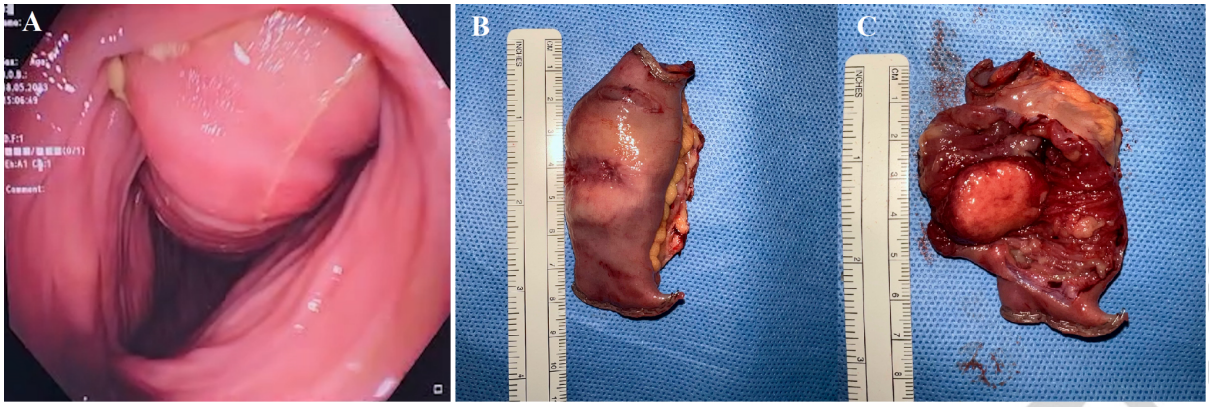

Fig. 2. A. Colonoscopy image showing ileocecal intussusception without signs of ileocolonic mucosal alterations or parietal distress. B. Surgical specimen: intestinal segment containing a centrally elongated hardened lesion on its outer wall. C. Surgical specimen: intraluminal aspect; a well limited, homogenic, mass arriving from the mucosa.

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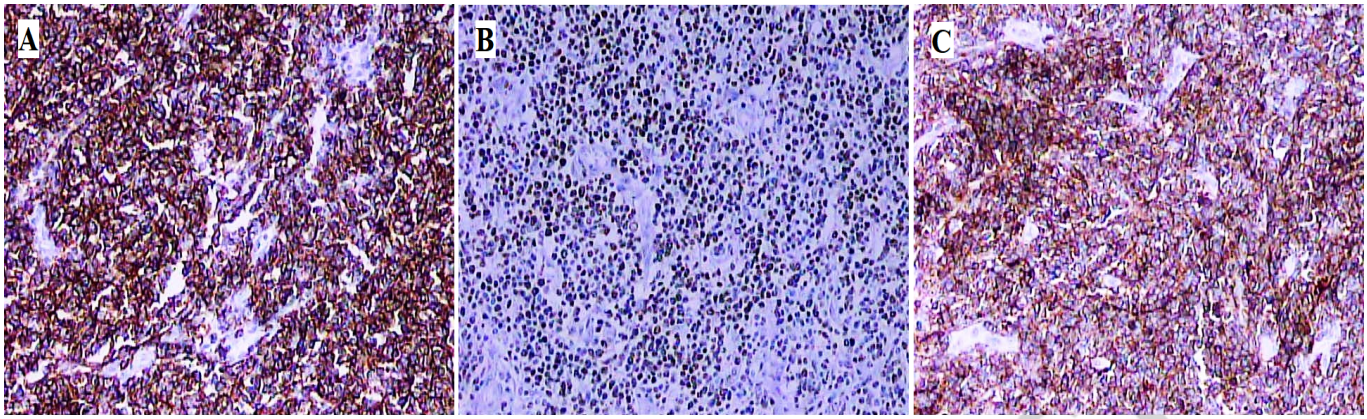

Fig. 3. Immunohistochemical test image of the surgical specimen. A. CD20+ in the membranes and cytoplasm of neoplastic cells. B. High Ki-67 expression. C. Diffuse CD10 expression in the neoplasia.