Case Report	
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Title	**Intussusception presenting as rectal prolapse: a case report**
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SUMMARY

Acute intestinal intussusception (AII) prolapsed through the anus, is a surgical emergency in infants considering the double risk of acute intestinal obstruction and perforation by necrosis of the prolapsed intestinal loop. Although AII is common in children, presentation as a rectally prolapsing mass is a rare. It is often secondary to the progression of the intussusception following intestinal peristalsis until its exit through the anus. We report a case of AII with a prolapsed sausage through the anus in an infant treated surgically with the aim of highlighting the diagnostic particularities and raising awareness among practitioners in order to avoid diagnostic delays.

An 8-month-old infant, was admitted with bowel prolapsed through the anus. The child had diarrhea and vomiting for 5 days. The AII diagnosis with a prolapsed sausage through the anus was noted 2 days later. Surgical exploration revealed gangrene of the prolapsed loop,. Child recovered well despite drop in platelets and hemoglobin. The 3-month follow-up is satisfactory.

KEYWORDS: Acute intestinal intussusception – rectal prolapse – sausagesausage – emergency – Brazzaville

INTRODUCTION

Acute intestinal intussusception is due to the telescoping of an intestinal segment and its mesentry in the lumen of the downstream segment Although the diagnosis is made early, presentation of AII prolapsing through the anus is noted as a rare late presentation. We report a case of AII with bowel prolapse through the anus in an 11-month-old baby in order to highlight the diagnostic delay involved due to other non-emergent differentials such as rectal mucosal prolapse and also to raise awareness among practitioners .

CLINICAL CASE

An eleven-month-old female infant, the younger of the two siblings, born of normal vaginal delivery with a birth weight of 2500g presented with mucoid and bloody stools approximately 5-6 times per day which was associated with incessant cry and fever

Mother gave history of self-medication for deworming the baby (mebendazole) and non-steroidal anti-inflammatory drug (ibuprofen) five days ago.. The baby was well for 3 days following which there was onset of recurrent postprandial vomiting and generalised weakness. The infant was taken to the pediatric emergency room of the Blanche Gomes Mother-Child specialized hospital in Brazzaville.

Clinical examination revealed a sick infant with stage II dehydration, fever of 38.3'C and emaciation (weight=5 kg). A small, reducible rectal prolapse was noted.

Initial investigations revealed leukocytosis with neutrophil predominance, hemoglobin 10.2g/l and a creatinine 5.2mg/l.

Plain abdominal radiograph (PAP) was unremarkable.

An ultrasound scan performed on day 1 of hospitalization outside the hospital revealed gastric distension pushing back the liver.

The course of action in the pediatric department consisted of resuscitation and parenteral iv metronidazole 30mg/kg/day and ceftriaxone 75mg/kg/day for 3 days.

The course was marked by worsening of the rectal prolapse which was irreducible. An opinion from the pediatric surgeon was requested on day 2 of hospitalization. At that time, the physical examination revealed a mobile para-umbilical right abdominal mass, a significant rectal prolapse with edema and a necrotic distal portion of the loop (**Figure 1**).

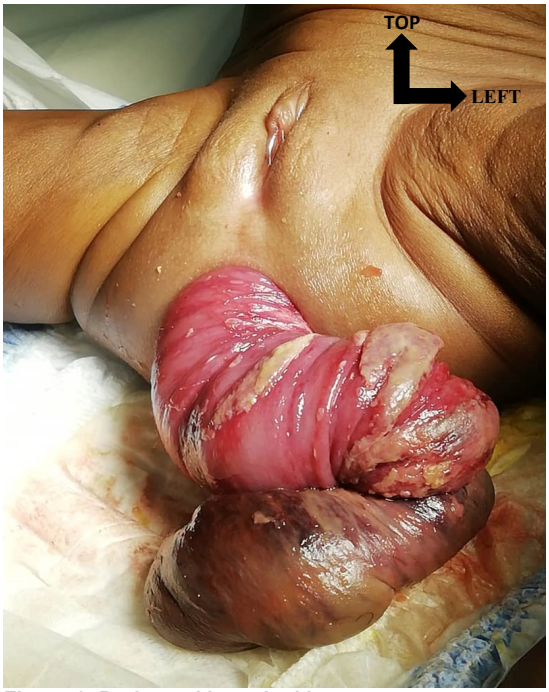

Figure 1: Prolapsed intestinal loop

The diagnosis of a prolapsed AII through the anus was made.

A second ultrasound scan performed 2 days after the first, done in the hospital, revealed colonic intussusception (probably sigmoid) with distension of the intestinal loops. Laparotomy was performed 24 hours later which revealed gangrene of the externalized loop, intussusception of ileocecal segment (**figure 2**) and an mobile cecum. Resection of the necrotic bowel, manual reduction and end-to-end ileo-colic anastomosis was performed.

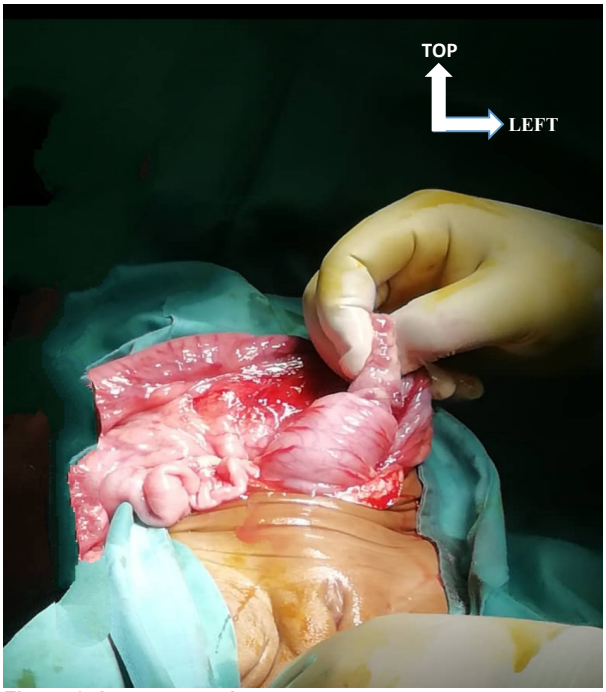

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Figure 2: intussusception sausage

Postoperatively, antibiotics were continued for ten days followed by oral cefixime at a dose of 8mg/kg/day. The immediate postoperative course (Day 1) was marked by anemia at 6g/dL and thrombocytopenia corrected by transfusions of packed erythrocytes and platelets. Enteral feeding was commenced on the 5th day. The removal of the sutures was carried out at one week. The discharge was decided on the 10th day after surgery.

Nutritional support was continued in the pediatric outpatient clinic. The anatomo-pathological examination of the surgical specimen was unremarkable. The child was on regular follow up at 1 week, at 1 and 3 months.

DISCUSSION

Prolapse of bowel is a rare complication of IIA. It was first described by CHIGOT in 1944 [3]. The frequency of this pathology remains low because the diagnosis of AII is made early in developed countries [2] . Nourri reports a rate of 3.2% [3], Weisgerber found 2% in his series [4], Chanvrier noted 1.97% [5] and 1.87% according to Lynn [6].

Isolated cases of this complication have been reported in the African pediatric literature [2 ; 7 ; 8]. In developing countries, a late consultation of more than 48 hours of patients is most often observed. [10 ; 11 ; 12 ; 13] .

In our case, surgical consultation was delayed by 5 days. The importance of delayed consultation in the management of intussusception lies in the increased risk of devascularisation of the intussuscepted bowel [2;14] and necessity of bowel resection.

The clinical picture of AII as described in the literature is the classic triad of paroxysmal abdominal pain, vomiting and rectal bleeding, which is not always present. Literature reports its presence in less than 55% of cases [15;16;17].

In our context, the child had been initially treated for worm infection and gastroenteritis. However, incessant crying associated with diarrhea and vomiting should raise the suspicion of the diagnosis.

The demonstration of anal prolapse in a diarrheal context in an infant should raise the suspicion of a prolapsed intussusception. Thoroughness in the clinical examination allows it to be differentiated from a simple prolapse rectal [2].

Prolapse through the anus of the intussusception was a late manifestation of AII in our infant. This observation has been reported by other African authors [7;18;19].

In our context, this demonstration reflects a diagnostic delay closely linked to a cultural failure to consult from the onset of symptoms; self-medication being its basis. This complication is likely due to lack of attachment of the colon and long small bowel mesentery allowing the progression of the intussusception over the entire colonic length till the anus [2;15] .

Ultrasound is the first investigation to confirm diagnosis. It has a sensitivity of 97.9%, a negative predictive value of 86.6% and a specificity 99.7% [16] when performed by a specialist. However ultrasound remains operator dependent . It is essential that it is performed by a pediatric radiologist. Two ultrasounds were requested 24 hours apart, thus delaying diagnosis in our case.

, Coming to intervention, surgery was performed 24 hours after the indication. Reason for this delay is related to lack of health insurance in our environment. When diagnosis is announced, the parents need to arrange for funds related to the treatment (radiological assessment, preoperative biochemistry, anesthetic and surgical prescription in addition to access to the operating room).

AII in our child was idiopathic - favored by a lack of attachment of the cecum. However, secondary forms occur classically in children aged less than 2 months or more than two years [17;18].

The seat of the intussusception in our child was ileocecal like those reported in the literature

[1;19]. Some authors have reported other forms such as ileo-caeco-colic, ileo-ileal or colo-colic [1 ;19]. Several authors have reported a disinvagination of the prolapsed AII by contrast enema [3; 20;21]. We have not attempted to reduce by enema due to the limited resources and bowel gangrene.
Nouri [3] reports a rate of 25% of intestinal necrosis, Ramachandran reports 18.75% [20] .
In our context, this delay in support is influenced by three factors

- Self-medication which is the basis of a cultural failure to consult at the onset of symptoms
- Confusing clinical picture (diarrhoea and vomiting) suggestive of non surgical features
- An initial non-contributory abdominal ultrasound and the non-availability of pediatric radiologist.

CONCLUSION

Prolapsed bowel is a rare complication of infant AII. High index of clinical suspicion is required to diagnose AII with bowel prolapse. In the setting of limited resources, early diagnosis and prompt surgical intervention is the key to improve patient outcome.

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Resilience of african children is remarkable. This girl tolerated intussusception, prolapse of bowel and gangrene of bowel for five days, and withstood major surgery including resection. She did not need intensive care. All this speaks well for the skills of surgeons and anesthetists working under difficult conditions. They deserve appreciation. Mobile cecum and colon saved the child. It allowed intussusception to progress without compromising bowel vascularity. Having a mobile cecum in childhood seems to have a protective effect.

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