A rare case of small bowel intussusception

A 58-year-old man was referred to our institution with a 2-month history of worsening colicky upper abdominal pain associated with eating and relieved by vomiting, and weight loss. Gastroscopy revealed grade B reflux esophagitis, erosive gastritis, and duodenitis. A *Campylobacter*-like organism (CLO) test was negative for *Helicobacter pylori*, and duodenal biopsies were normal. Empirical triple therapy with amoxicillin, clarithromycin, and omeprazole was administered. An abdominal ultrasound was normal. A barium follow-through showed an unusual jejunal appearance with dilatation also noted (Fig. 1). Subsequent CT enterography suggested proximal jejunal tethering. Double-balloon enteroscopy (DBE) revealed, 10cm beyond the ligament of Treitz, a large sessile, ulcerated 3–4cm lesion, hemicircumferentially involving the small bowel wall (Fig. 2). Multiple biopsies were taken and a tattoo was placed proximal to the lesion. Histopathological analysis showed a dense lymphoid infiltrate including aggregates/germinal centers with perivascular activity, highly suggestive of lymphoma. Immunohistochemistry confirmed low grade B-cell mucosa-associated lymphoid tissue (MALT lymphoma).

At 2 weeks after a first cycle with R-CVP (rituximab, cyclophosphamide, vincristine, prednisolone), the patient presented with severe abdominal pain. A computed tomography (CT) scan revealed jejunal intussusception (Fig. 3), but surgical review recommended conservative management. A second DBE showed no change in the lesion (Video 1) after three further cycles of R-CVP. For this reason, the patient’s chemotherapy was changed to a more aggressive scheme with R-CHOP (rituximab, cyclophosphamide, hydroxydaunorubicin, oncovin, and prednisone) for a further three cycles, and a third DBE revealed a marked improvement with significant regression of the mass (Fig. 4, Video 2).

MALT lymphoma is the commonest extranodal small B-cell non-Hodgkin’s lymphoma [1]. Of extranodal lymphomas, 37% occur in the gastrointestinal tract, with 7.5% involving the small bowel [2]. While almost 90% of gastric MALT lymphomas are caused by *Helicobacter pylori* [3], the etiology of jejunal MALT lymphoma is uncertain [4]. DBE is a useful tool for the diagnosis and follow-up of small bowel lymphoma [5].

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**Video 1**

Double-balloon enteroscopy (DBE) showed no change in the lesion after four cycles of R-CVP (rituximab, cyclophosphamide, vincristine, prednisolone).

**Video 2**

After three cycles of R-CHOP (rituximab, cyclophosphamide, hydroxydaunorubicin, oncovin, and prednisone), double-balloon enteroscopy (DBE) revealed a marked improvement with significant regression of the mass.

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**Fig. 1** Unusual jejunal appearance with dilatation, shown by a barium follow-through (typical coiled spring appearance: large arrow, intussusceptum; small arrow: intussuspiens).

**Fig. 2** a, b A large sessile, ulcerated 3–4cm lesion, hemicircumferentially involving the small bowel wall.

**Fig. 3** Jejunal intussusception revealed by computed tomography (CT) scan: a axial view; b coronal view.
Endoscopy_UCTN_Code_CCL_1AC_2AC

Competing interests: The first author has a Research Grant in deep enteroscopy released by Imotec/Fujinon.

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References

Fig. 4 Marked improvement with significant regression of the jejunal lesion at double-balloon enteroscopy (DCE).

Murino A et al. A rare case of small bowel intussusception... Endoscopy 2012; 44: E157–E158

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DOI: http://dx.doi.org/10.1055/s-0031-1291744
Endoscopy 2012; 44: E157–E158
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X