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. Subsequent CT enterography suggested proximal jejunal tethering. Double-balloon enteroscopy (DBE) revealed, 10 cm beyond the ligament of Treitz, a large sessile, ulcerated 3–4 cm lesion, hemicircumferentially involving the small bowel wall. 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, but surgical review recommended conservative management. A second DBE showed no change in the lesion after four 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.

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].
A. Murino, E. J. Despott, A. Hansmann, P. Heath, C. Fraser

1 Wolfson Unit for Endoscopy, St Mark’s Hospital and Academic Institute, Imperial College London, Harrow, London

2 Department of Radiology, St Mark’s Hospital and Academic Institute, Imperial College London, Harrow, London

3 Department of Haematology, Northwick Park Hospital, Harrow, London

References


Corresponding author
A. Murino, MD
Wolfson Unit for Endoscopy
St Mark’s Hospital and Academic Centre
Watford Road
Harrow
Middlesex
HA1 3UJ
UK
Fax: +44-1702-444224
albertomurino@yahoo.it

Bibliography
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

Endoscopy_UCTN_Code_CCL_1AC_2AC

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

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