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A Rare case of GOO due to Gastro-duodenal Intussusception caused by Duodenal Polyp

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ABSTRACT

Gastroduodenal intussusception is a rare pathological condition in adults, often associated with an identifiable lead point such as a tumour or polyp. We report a case of a 65-year-old male presenting with recent worsening epigastric pain, chronic dyspeptic symptoms along with postprandial vomiting. Imaging revealed gastroduodenal intussusception, and endoscopy demonstrated a pedunculated duodenal polyp. Surgical exploration confirmed a large pedunculated polyp arising from the first part of the duodenum, acting as the lead point for intussusception. The lesion was successfully excised, and histopathology confirmed a benign adenomatous polyp. This case highlights the importance of considering structural causes in chronic dyspepsia and demonstrates a rare but important cause of adult intussusception.

Key words: Gastroduodenal Intussusception; Duodenal Polyp; Gastric Outlet Obstruction

CASE PRESENTATION

We report a case of 65-Year-old male patient presented to the hospital with chief complaint of epigastric pain and postprandial vomiting since the past 3 months. Patient also reported fatigue, dyspepsia, epigastric discomfort, heart burn, belching and anorexia, which had been unresponsive to any symptomatic medication over the last 15 years, but associated with increase in severity of symptoms for the past 3 months. He denied hematemesis, melena, and comorbidities, with no significant past or family history. On Examination, anaemia and mobile mass per abdomen were noted. He was admitted in the hospital for further work up and management. Routine investigations were ordered and USG abdomen was done followed by upper GI endoscopy with biopsy showing Duodenal polyp at second portion of duodenum(D2) with thick stalk in first portion of duodenum (D1), ruling out malignancy. MRI Abdomen was ordered, which shows Gastro Duodenal Intussusception with D2 polyp. Patient was planned for surgery after receiving multiple blood transfusions and relevant investigations. Pre operative evaluation was done and under general anaesthesia, abdomen was opened in layers to enter the abdominal cavity. The duodenum was mobilized and manual reduction of Intussusception was done by pushing the lesion proximally (Figure-1). A duodenotomy was performed by giving transverse incision in D2. A, single cauliflower-like pedunculated polyp of size 5x3 cm with a stalk of diameter 1 cm arising from proximal portion of D1was noted (Figures 1,2). The polyp along with its stalk was excised and the

specimen was sent for frozen section analysis. Frozen section reported it as a benign adenomatous polyp. The duodenum was closed in two layers, followed by layered closure of abdomen.

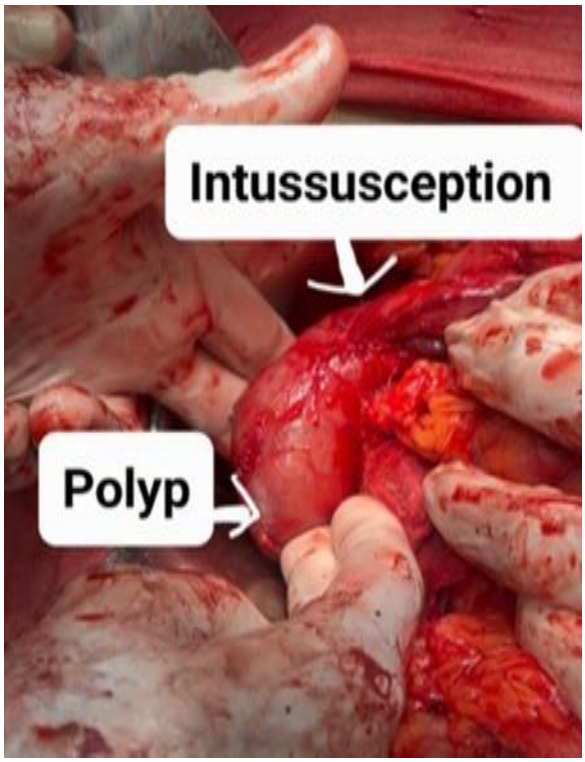

Figure 1: Duodenal polyp and Gastroduodenal Intussusception.

Figure 2: Intra operative findings of polyp

DISCUSSION

Gastroduodenal intussusception is a rare diagnostic entity in adults and is almost always associated with a pathological lead point. In contrast to paediatric intussusception, which is typically idiopathic, adult cases are most commonly secondary to structural lesions such as benign or malignant tumours, polyps, or submucosal masses.[1] As described by Hsieh YL et al., gastroduodenal intussusception is a rare condition most frequently caused by gastric neoplasms, particularly gastrointestinal stromal tumours (GISTs), which act as a lead point and result in telescoping of the proximal bowel into the distal segment.[2] In contrast, our case demonstrates a rare aetiology involving a large pedunculated adenomatous polyp arising from the first part of the duodenum. The long stalk and mobility of the lesion likely promoted its prolapse into the distal duodenum, leading to intussusception. Clinically, adult intussusception often presents with nonspecific symptoms such as intermittent abdominal pain, vomiting, anaemia, and features of gastric outlet obstruction, frequently leading to delayed diagnosis.[3] Chronic dyspeptic symptoms, as observed in our patient, may obscure the underlying structural pathology until complications arise. Definitive management in adults is primarily surgical due to the high likelihood of an underlying lesion, with resection being both diagnostic and therapeutic.[1] This case highlights a rare benign cause of gastroduodenal intussusception and emphasizes the importance of maintaining a high index of suspicion for structural lesions in patients presenting with long-standing dyspepsia and new-onset obstructive symptoms.

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