Post-Prandial Vomiting and Abdominal Pain: A Case Report

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Post-Prandial Vomiting and Abdominal Pain: A Case Report

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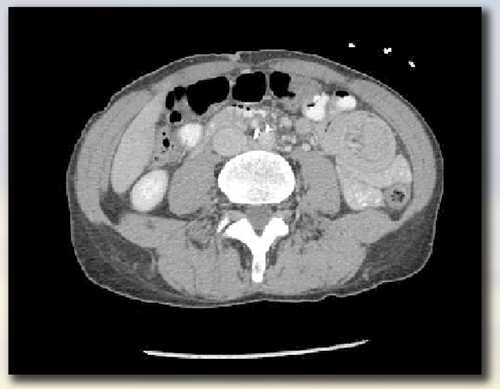
Case Presentation:

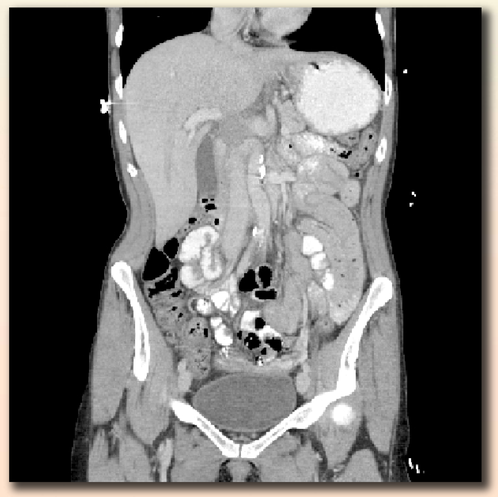
Intussusception commonly occurs as a cause of small bowel obstruction in children, but approximately five percent of cases occur in adults. We describe a case of a forty-six year old female with intussusception of the small bowel. The diagnosis was identified in the emergency department based on clinical picture (palpable mass in the left abdomen) and computed tomography (CT) scan of the abdomen and pelvis. She was treated with bowel rest, nasogastric tube for low intermittent suctioning, and intravenous fluid (IV) resuscitation and pain medication. Over several days, the intussusception cleared and she was discharged home.

The patient presented to the emergency department with a history of post-prandial abdominal pain and vomiting for two weeks. She complained of loose stools, but no diarrhea or bloody stools. She reported an unintentional twelve-pound weight loss over the last month. No other family members had the same complaints. She reported no recent travel, diet changes, camping, or antibiotic use.

On examination of the patient, she appeared uncomfortable. Her abdomen was scaphoid and she had diffuse tenderness. Upon palpation, a left sided non-pulsatile mass was appreciated. She showed no signs of rebound tenderness or guarding. Rectal exam revealed hemoccult negative stool. A contrast enhanced (oral and intravenous) CT scan of the abdomen and pelvis revealed intussusception of the jejunum extending approximately 9 cm craniocaudal in the left midabdomen. This was persistent on delayed scans, but no mass or bowel obstruction was demonstrated. She was treated with bowel rest, nasogastric tube for low intermittent suctioning, intravenous (IV) fluid resuscitation, and pain medication. Over several days, the intussusception cleared and she was discharged home.

This case describes an uncommon abdominal process in adults. Intussusception in adults is commonly associated with an underlying pathologic process including neoplasms, inflammatory lesions, and Meckel's diverticula. The classic triad of symptoms is abdominal pain, vomiting, and bloody stools. The majority of patients can be managed conservatively with admission to the hospital, maintenance IV fluids, nothing by mouth, and nasogastric tube if vomiting continues. Intestinal resection is reserved for those instances when the bowel is not viable. Our patient successfully recovered with conservative treatment alone. Approximately six weeks later, the patient had both an outpatient ultrasound and colonscopy. Neither study revealed an etiology or recurrence of the previous intussusception. The etiology of the patient's pathology was not identified.





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