Case 2: A 62-year-old man presented with recurrent vomiting and weight loss for a period of 4 weeks. He was suffering from osteoarthritis, for which he had been taking various combinations of ibuprofen and paracetamol for the previous 5 years. He had lost nearly 6 kg of weight in the preceding 4 weeks. Physical examination revealed mild pallor and a loud succussion splash. Upper GI endoscopy revealed two webs in the duodenum, 5 cm apart; the distal web would not allow the passage of the endoscope (Fig). Barium meal follow-through study showed an additional web distal to the second web. Each of these webs was visualized using a standard sphincterotome. At follow up the patient was asymptomatic; barium meal upper GI study revealed resolution of the diaphragms. The patient gained 5 kg of weight over a period of two months.

Case 3: A 63-year-old man presented with history of abdominal pain and vomiting of 4 months' duration, suggestive of gastric outlet obstruction. Endoscopy and barium meal studies showed the presence of four webs localized to the second part of the duodenum. We have previously reported the successful management of this patient using a standard ERCP sphincterotome.1

Intestinal diaphragms or webs, which were initially reported in the ileum, may also occur in the duodenum and colon.2,3 Two of the three patients in our report had multiple webs spread between the second and third parts of the duodenum. The diameter of the lumen in the region of the webs ranged from a pinhole to mild narrowing through which the endoscope could easily be maneuvered. The thickness of these webs as seen on barium follow-through studies was about 2-3 mm.

The occurrence of duodenal lesions in our patients is probably due to the fact that, unlike in the West where enteric-coated/delayed-release NSAIDs are the norm, in India and other developing countries non-enteric-coated NSAIDs are used more often. Each of our patients had been taking NSAIDs for periods ranging from 5-15 years. This is similar to the observation of Lang et al.,1 where the median duration was 15 years. Incision of the lumen-compromising webs was carried out over 1-2 sessions using a standard sphincterotome. No immediate complications were seen. The tensile strength of the web was probably responsible for the unsuccessful pneumatic dilatation in one patient.

Because of their relative rarity, the possibility of NSAID-induced intestinal diaphragms may be overlooked. These should be considered in the differential diagnosis of a patient taking these drugs who presents with features of intestinal or gastric outlet obstruction.

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Inflammatory fibroid polyp of jejunum causing jejunoojejunal intussusception

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Intussusceptions originating in the jejunum are rare. We report a 20-year-old woman who had a chronic jejuno-jejunal intussusception due to an inflammatory fibroid polyp manifesting in the post-partum period as peritonitis. Resection-anastomosis of the intussuscepted segment was done. She is well one year later. [Indian J Gastroenterol 2004;23:190-192]

Key word: Peritonitis

Intussusception is most often encountered in children at the ileocolic level, usually due to hyperplasia of Peyer's patches in the terminal ileum.

A 20-year-old woman was referred with complaints of severe central and lower abdominal colicky pain for the previous 3 weeks following a forceps-assisted delivery of an intrauterine death during the 8th month of pregnancy. She denied any associated loose stools, vomiting or dysuria. She had intermittent moderate fever with chills and rigors for the past 2 weeks and was treated symptomatically for urinary tract infection. She had similar attacks of mild pain associated with bloodtinged stools during the later months of her pregnancy.

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Abdominal examination revealed diffuse tenderness maximally located in the suprapubic region. Leukocytic count was elevated (11,200/mm³) and urine examination revealed plenty of pus cells. Abdominal X-ray showed a few grossly distended loops of small intestine with absent colonic shadows, suggestive of mid-bowel obstruction. Ultrasonography showed minimal free fluid in the peritoneal cavity with a localized collection in the pelvis amidst distended bowel loops and a bulky intraventricular uterus.

Diagnostic laparoscopy revealed grossly distended proximal small bowel loops with an intussusception in mid-jejunum. A small amount of free, purulent fluid was also observed in the peritoneal cavity. Enlarged lymph nodes were noted at the site of the intussusception. The intussuscepted segment was brought out through a small extension of the umbilical trocar site and resected, and end-to-end anastomosis was carried out extracorporeally. Her postoperative period was uneventful and she was discharged on the third day after surgery. Almost a year after surgery, she has had no further attacks of pain.

Gross examination of the 60-cm-long specimen showed severe serosal inflammation of the intussuscepted segment of jejunum. A pedunculated polyp measuring 6 cm x 4 cm with a 0.5-cm-long pedicle and with extensive small ulcersations on the surface was found at the leading edge of the intussusception along the antimesenteric border. The cut surface of the polyp showed large areas of hemorrhage peripherally, while the center and pedicle displayed a gray-yellow coloration (Fig); there was no necrosis.

Microscopy revealed edematous stroma comprising plump spindle cells loosely arranged in a concentric fashion around a large number of blood vessels of varying caliber. Interspersed among the cells were numerous eosinophils, scattered neutrophils and lymphocytes. Extensive hemorrhage was also apparent peripherally. The muscularis propria and adjacent jejunum also showed diffuse eosinophilic infiltration. The resected lymph nodes displayed reactive hyperplasia. Immunohistochemistry revealed a negative reaction for smooth muscle actin, but CD34 was positive. A diagnosis of inflammatory fibroid polyp of the jejunum was made.

Ileocolic intussusceptions account for the bulk of intussusceptions, followed by ileocolic, ileocecal and colocolic. Jejuno-jejunal intussusception is rare, probably because mass lesions in this location are infrequent. Jejuno-jejunal intussusception resulting from inflammatory fibroid polyps (IFP) was first described in 1986 by Winkler et al.²

IFP are submucosal masses that can arise anywhere in the gastrointestinal tract but are commonly found in the distal pylorus and distal ileum.² They can occur at any age, with the 6th and 7th decades affected the most.²,⁵ They are generally small, with a median size of 1.5 cm; larger lesions produce symptoms related to bowel obstruction and intussusception.² An greater incidence of IFP has been reported from Malawi in Africa.¹

The etiology is uncertain; a reactive process is favored.¹,⁵ Secondary degenerative and inflammatory changes in leiomyomas may account for some cases.¹

IFP appear grossly as sessile or polypoid, solitary or multiple, circumscribed, round to ovoid nodules, and occasionally as nodular thickening of the bowel wall.³

The microscopic features¹ are similar to those in our patient. Unusual features include granulomas with multinucleate giant cells, calcification and hyalinization of the fibrous tissue.¹,⁵ Terminal ileal IFP are larger, with extensive ulceration, more edematous stroma, more stellate than spindle cells, and more mixed inflammatory cells.¹ The spindle cells are immunoreactive for vimentin,¹ CD34 positivity suggests an origin from primitive perivascular or vascular cells. Ultrastructurally, the cells show features of fibroblasts and histiocytes.³

Treatment is generally resection of the involved intestine. There has been no reported recurrence of IFP. In the patient we report, the unusual features were the clinical presentation, the young age, the unusually large tumor, and incidental intrauterine death of the fetus.

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