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Case Report

Case Report

A case of intussusception secondary to a metastatic malignant melanoma from the nasal cavity

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Abstract

About 5% of all intussusception are found in adults, up to 90% of these have an anatomical lesion with ∼50% of them are malignant. Malignant melanoma commonly metastasizes to the small bowel; however, melanoma causing intussusception is rare. We describe a 57-year-old lady with a history of surgically treated malignant melanoma in her nasal cavity who came with an ambiguous intestinal obstruction. Computed tomography reported ileal-ileal intussusception, which was surgically removed via emergency open laparotomy and bowel resection. Intraoperatively the intussusception was 110 cm from the ileo-cecal valve with multiple palpable lymph nodes. Histopathology confirmed the origin as malignant melanoma with lymphovascular invasion. Our literature review found the mean prevalence of intussusception secondary to melanoma was 6.924% (SD ± 5.155). Minimally invasive techniques are reported non-inferior to open laparotomy. We argue that the open technique can provide informed decisions for adequate resection of affected bowel and lymphatic drainage.

Keywords: adult intussusception; malignant melanoma; malignancy in intussusception; epidemiology; lymphovascular invasion; small bowel resection

Introduction

Intussusception is defined as the invagination of one segment of the bowel (the intussusceptum) into an adjacent distal segment of the bowel (the intussuscipien) [1]. Intussusception in adults is rare and is estimated at ∼5% of all intussusception, and the presence of an anatomical lesion has been reported in 70–90% of cases, with 50% being malignant [3]. Malignant melanoma is one of the most common carcinomas to metastasize to the gastrointestinal tract, followed by breast and lung cancer [4]. However, malignant melanoma as a cause of small bowel intussusception is rare, reported since the 80s, but still rarely described until today [5]. We describe a case of small bowel intussusception secondary to a distant metastasis of malignant melanoma from a rare source from the nasal cavity with a literature review on the current methods of treatment. This report was written according to the CARE checklist.

Case report

Our patient is a 57-year old lady who presented with 1 week of generalized body weakness with on and off epigastric pain associated with nausea, loss of appetite, bloatedness, not passing flatus for 3 days, and constipation for 4 days. She has a history of malignant melanoma from the left nasal cavity with metastasis to the lungs and left adrenal gland. She underwent endoscopy assisted left lateral rhinotomy and was on her third cycle of Dacarbazine before admission.

Physical examination revealed a vague, nonspecific abdominal tenderness during her initial presentation to our hospital. A nasogastric tube was inserted to decompress her stomach initially. During admission, she developed 10 episodes of vomiting clear fluids and her epigastric region started to distend. Her right lumbar and umbilical region became tender on palpation. By this time, her nasogastric tube drained ∼1000 mls of greenish stomach content. Otherwise, she was able to pass motion and flatulence.

Investigations

Her abdominal x-ray showed a dilated small bowel with a most likely transition point at the ileum and a collapsed large bowel (Fig. 1). Computed tomography (CT) of the abdomen showed an intussusception with the transition point at the proximal ileum with mesenteric invagination (Figs. 2 and 3).

Management

Our patient underwent an urgent midline laparotomy and small bowel resection with primary anastomosis of the small bowel.

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