

us initially think of an association. However, her second admission ruled out this aetiology.

A recent article by Tenner,⁶ which questions the existence of drug-induced pancreatitis, is extremely interesting. The author argues that there is sufficient evidence of causation for only 2 drugs (azathioprine and didanosine [DDI]), based on randomised and cohort studies, while for most of the other drugs implicated, only isolated cases with insufficient scientific basis and no drug rechallenge have been published. The diagnosis of drug-induced pancreatitis is not easy, as it is not associated with clinical findings such as a rash, or laboratory findings like eosinophilia. It is unwise to establish a diagnosis purely on the basis of abdominal pain and elevated amylase levels (both factors present in many other abdominal processes). If aetiology is attributed to a drug, confounding factors (such as the association between exenatide and acute pancreatitis described by Tenner) must always be borne in mind.

Nevertheless, the most reasonable approach when drug-induced pancreatitis is suspected is to withdraw the drug and avoid re-introduction (as described by Cerezo et al.). If the symptoms resolve and there is no other possible cause (we did not perform Oddi sphincter manometry as this was not available in our hospital), an aetiological relationship is possible, but not easy to prove. A firm diagnosis can only be made if the pancreatitis reoccurs on drug rechallenge.

Thus, according to Tenner,⁶ establishing a causal relationship between a drug and the development of acute pancreatitis is not easy, both due to the complexity of collecting data which may contain bias and confounding factors, and to the ethical limitations of drug rechallenge. It is important to be extremely wary when associating a drug with the development of acute pancreatitis, and bear in mind the existence of acute idiopathic pancreatitis.⁷

Conflict of interests

The authors declare that they have no conflict of interests.

Adult colocolonic intussusception due to adenomatous polyp: An exceptional cause of a rare entity[☆]



Invaginación colocolónica en adulto por pólipo adenomatoso: una causa excepcional de una entidad poco frecuente

To the Editor,

Colonic intussusception in adults is a rare process, normally caused by malignant lesions, which are treated surgically.¹⁻⁴

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However, there are some cases in which the origin of this disease is benign, such as stromal tumours, lipomas, appendiceal mucoceles^{2,5-7} and polyps.^{2,8,9} We present the case of a patient with intussusception of the sigmoid colon caused by a large adenomatous polyp, diagnosed by computed tomography (CT) and treated by endoscopic polypectomy.

The patient was a 55-year-old man, a heavy smoker, with no family history of interest and no previous surgical interventions. He had been diagnosed 1 year previously with lung cancer, stage T4N2M0; no pathological lesions in the colon or abdominal lymphadenopathies were observed on the tumour staging CT scan. He had a complete response to radio- and chemotherapy. A follow-up CT scan upon completion of treatment revealed an image at the level of the splenic flexure consistent with colocolonic intussusception, apparently caused by a 32 mm × 32 mm solid endoluminal lesion, located at the head of intussusception (Figs. 1-3). No retrograde dilation of the colon or signs of bowel loop involvement were observed, and the patient was asymptomatic.

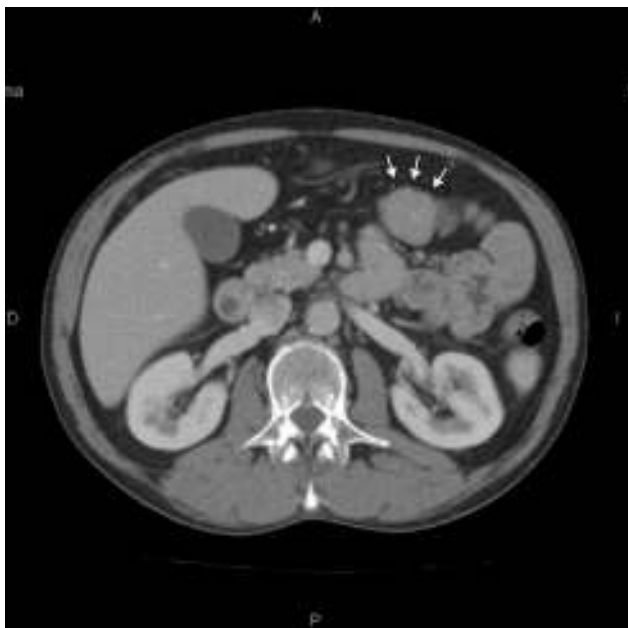


Figure 1 Computed tomography showing the location of the polypoid lesion (→) located at the head of intussusception, causing it.



Figure 2 Computed tomography. The polypoid lesion can be seen contiguous with the intussusception (→) and the invaginated loop (*).

Colonoscopy showed the lesion observed on the CT at the level of the splenic flexure, which corresponded to a polyp with a morular appearance measuring 35 mm in diameter, with a villous surface and a short, narrow pedicle, occluding the colonic lumen almost completely but allowing a conventional colonoscope to pass, albeit with some difficulty. After infiltrating the base of the pedicle with 5 mL of diluted adrenalin (1/10 000), the polyp was resected in a single fragment with a diathermal loop, with

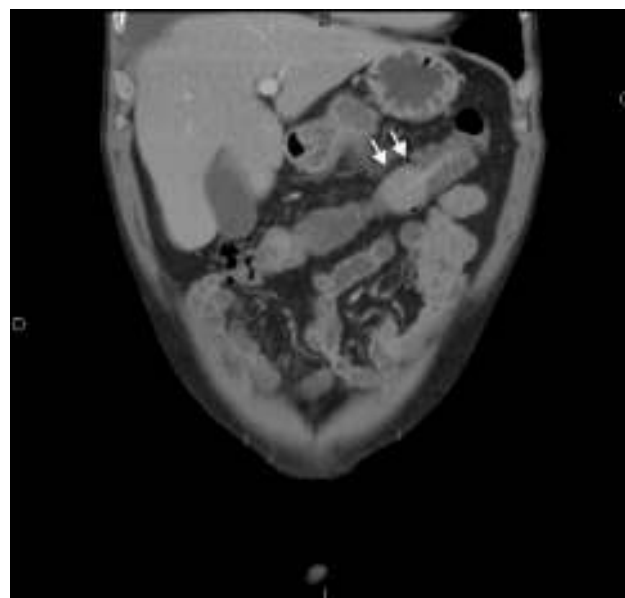


Figure 3 Computed tomography (coronal slice). The polyp causing the intussusception can be seen (→).

no immediate or late complications. The colonoscopy was completed to the caecum; no other lesions such as diverticuli or stenosis were observed. Histological analysis of the polyp classified it as villous adenoma with low-grade dysplasia.

Intestinal intussusception is defined as the introduction of a segment of loop inside the lumen of the contiguous intestinal segment, and is an entity characteristic of childhood, presenting in adulthood in only 5% of cases. In the adult population, this disease is the cause of between 1% and 5% of intestinal obstructions; its main location (90% of cases) is the small intestine, although it can include part of the colon (ileocolic forms). In adults—unlike paediatric patients—the intussusception is usually caused by an organic lesion (chronic inflammatory bowel disease, benign or malignant intraluminal lesions, metastases, foreign bodies, Meckel diverticulum, etc.) or by postoperative adhesions, although 8–20% are idiopathic.^{1–4,8}

In contrast, colocolonic intussusceptions are much less common and have a predominantly malignant origin.^{2,3} There are exceptions where the causal lesion is benign, usually a lipoma. Although cases have been described with other lesions such as stromal tumours^{2,4–7} or adenomatous colonic polyps, very few have been published.^{2,8,9}

Unlike children, in whom abdominal pain or a palpable abdominal mass predominates, symptoms in adults are usually non-specific, periodical, or even asymptomatic, as in our patient.^{1,2,4} This entity should be borne in mind in order to reach a prompt diagnosis.

The most useful diagnostic test is CT, especially in patients with few or non-specific symptoms.^{2–4,9,10} Other imaging tests such as plain radiographs, opaque enema or magnetic resonance may have a role. Some cases are only diagnosed during surgery.^{2–4,8}

Treatment of intussusception is normally surgical, either because it is found in the small intestine or due to the predominance of malignant lesions in the colon.^{2–4,9} However,

in the few cases in which colonic intussusception is due to a polypoid lesion, it can be treated by endoscopic resection, as in our patient.

Conflict of interests

The authors declare that they have no conflict of interests.

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