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Colonic intussusception caused by anisakiasis. A rare cause of obstruction☆

Invaginación colocólica por anisakiasis, una causa infrecuente de obstrucción intestinal

Dear Editor,

Intussusception is a rare cause of obstruction in adults. The most frequent location is the small intestine, with colonic intussusception accounting for only 5% of all cases. Most cases are due to an underlying cause which, in the colonic form, is usually a neoplasm. Benign causes are rare, and colonic anisakiasis is an exceptional aetiology.[1,2]

A 48-year-old woman came to the emergency department with mesogastric colic pain lasting 24 hours. She reported nausea, without vomiting, and absence of intestinal transit. A tender, palpable periumbilical mass was identified in the examination. Laboratory results showed elevated levels of acute phase reactants, moderate leukocytosis, but no eosinophilia. A CT scan was performed due to suspicion of a complicated tumour, and colonic intussusception of

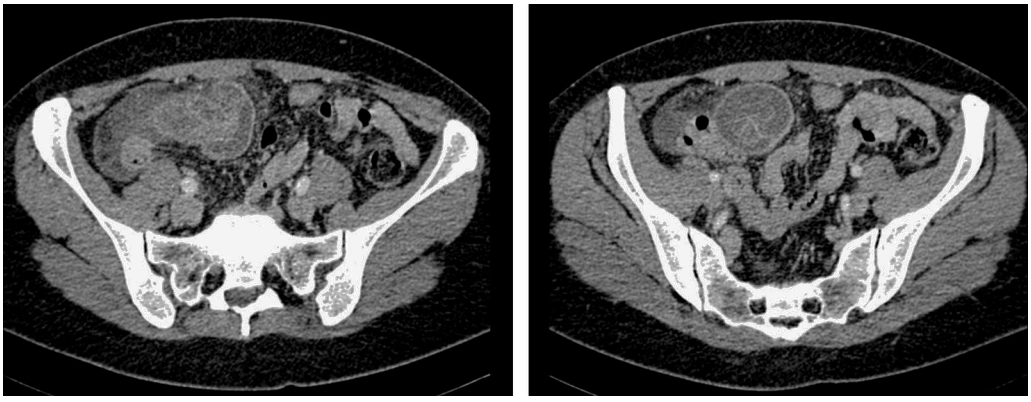

Figure 1 Axial slice of CT scan, showing the typical reniform and target-like patterns.

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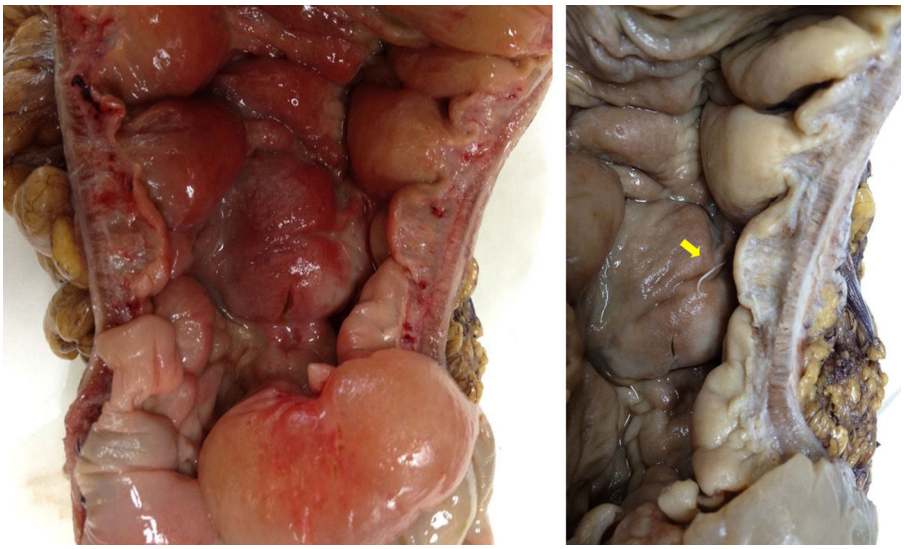

Figure 2 Fresh specimen and formalin-fixed specimen showing the parasite.

uncertain aetiology was observed, with fluid collection in the right iliac fossa and recto-uterine pouch, as well as evidence of intestinal distress (Fig. 1). Performing a colonoscopy was ruled out due to the suspicion of complicated tumour, and urgent surgery was decided on the basis of the CT findings. The laparotomy showed colonic intussusception extending from the start of the ascending colon to the transverse colon, with no caecal involvement. A right hemicolectomy was performed, with good postoperative progress. Pathological anatomy identified a whitish, filiform structure compatible with an anisakid nematode located in the mucosa of the ascending colon (Fig. 2), as well as significant oedema and inflammatory eosinophilic infiltrate, causing colonic intussusception (Fig. 3).

Colonic intussusception caused by anisakiasis is a rare entity that usually presents in the ascending colon, although it can sometimes occur in the sigmoid colon and rectum.[1,3] Preference for the ascending colon is probably due to the

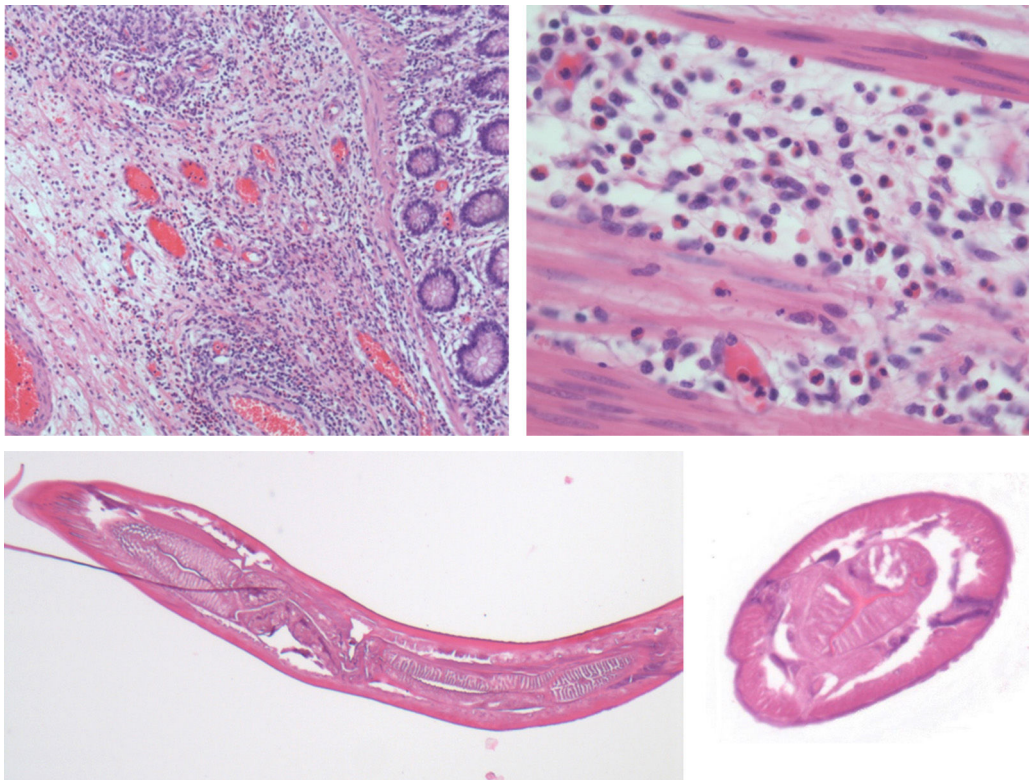

Figure 3 Eosinophilic colitis with significant oedema and inflammatory infiltrate, with the presence of eosinophils. Longitudinal and cross section of the parasite.

distance from the entry point, as the larva must travel from the mouth to the colon, and its survival is affected by the pH changes that occur along the gastrointestinal tract.[3,4] Colonic intussusception, i.e. the telescoping of a segment of colon into the lumen of the adjacent segment, is very rare, and is usually caused by a malignancy. For all these reasons, anisakiasis is an exceptional cause of colonic intussusception. Only 6 cases of colonic intussusception due to anisakiasis have been described in the literature, in addition to this case.[1,4–8]

Accurate diagnosis is difficult, especially in the absence of a history of fish consumption. In cases of diagnostic suspicion, colonoscopy can reduce the intussusception and confirm the diagnosis of anisakiasis.[3] Ultrasound can be useful in the diagnosis of intussusception, but the CT scan is the method of choice because it can pinpoint the site of intussusception and assess the extent of the obstruction and intestinal viability.[5] Three CT patterns considered pathognomonic of intussusception have been described: the target-like pattern (round mass with intraluminal soft-tissue and eccentric fat density due to the invaginated mesentery), the reniform pattern (a bilobed mass with high peripheral attenuation due to thinning of the bowel wall) or lesion with alternating areas of attenuation related to the bowel wall, mesentery, fluid, contrast material, or gas.[2]

When the diagnosis is suspected, treatment can be conservative, with nil by mouth and fluid therapy, anthelmintics and corticosteroids to reduce parietal oedema, in addition to endoscopic reduction of the intussusception. However, in the absence of a definitive diagnosis, the optimal treatment is not clearly established. Surgery tends to be necessary in most cases due to obstruction, perforation or suspicion of underlying malignant lesions, since anisakis infection produces submucosal tumours that are the cause of the intussusception and require a histological differential diagnosis.[1,4,5]

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Single colonic polyp as a presentation of mantle cell lymphoma☆

Pólipo único colónico como forma de presentación de linfoma del manto

Mantle cell lymphoma, which was first described in 1991 and recognised by the World Health Organisation (WHO) as a disease in 1994, is a type of B-cell non-Hodgkin lymphoma originating from B lymphocytes located in the mantle of a lymph node. It is characterised by expression of B-cell lineage markers (CD19, CD20 and CD5), where CD3, CD10 and CD23 are negative and a chromosomal translocation t(11; 14) causes overexpression of cyclin D1.[1] Mantle cell lymphoma is a rare type of B-cell non-Hodgkin lymphoma, and accounts for just 3–10% of all non-Hodgkin lymphomas.[2] Its incidence in Spain is very low (0.5 per 100,000 inhabitants/year),[3] mainly affecting men (2:1) and individuals over 60 years of age. This aggressive lymphoma has a mean survival of 3–5 years after diagnosis,[1] but, thanks to therapeutic advances and intensive strategies, survival has doubled in the last decade (60% survival at 5 years).[4]

Gastrointestinal involvement, with an incidence of 10–25%, is rare, with the most common manifestation being multiple lymphomatous polyposis, in which multiple lymphoid polyps are identified in the large and small intestine. The polyps usually occur in the ileocaecal region, although they can develop at any site from the stomach to the rectum.[5] They affect the colon and rectum in 90% of cases, the small intestine in 69%, the stomach in 57%, and the duodenum in 52%.[6] Endoscopic diagnosis is rare. Cases with microscopic invasion and normal mucosa on examination have been reported.[4]

We present the case of a 41-year-old man with a history of hypercholesterolaemia. He was seen by the gastroenterologist due to an increase in the number of bowel movements and rectorrhagia lasting several days, with no other accompanying symptoms and no weight loss,

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