INTUSSUSCEPTION WITH A LEAD POINT

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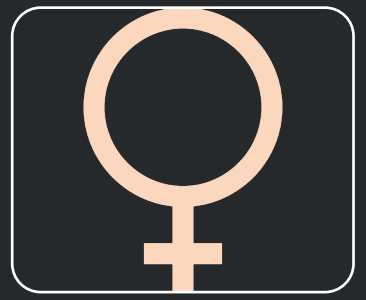
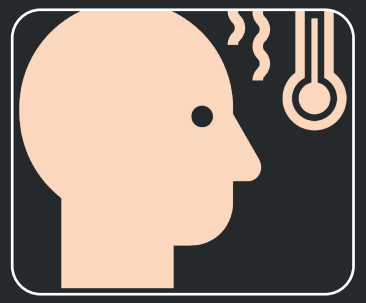
BSGAR

CLINICAL DETAILS



47-year-old female

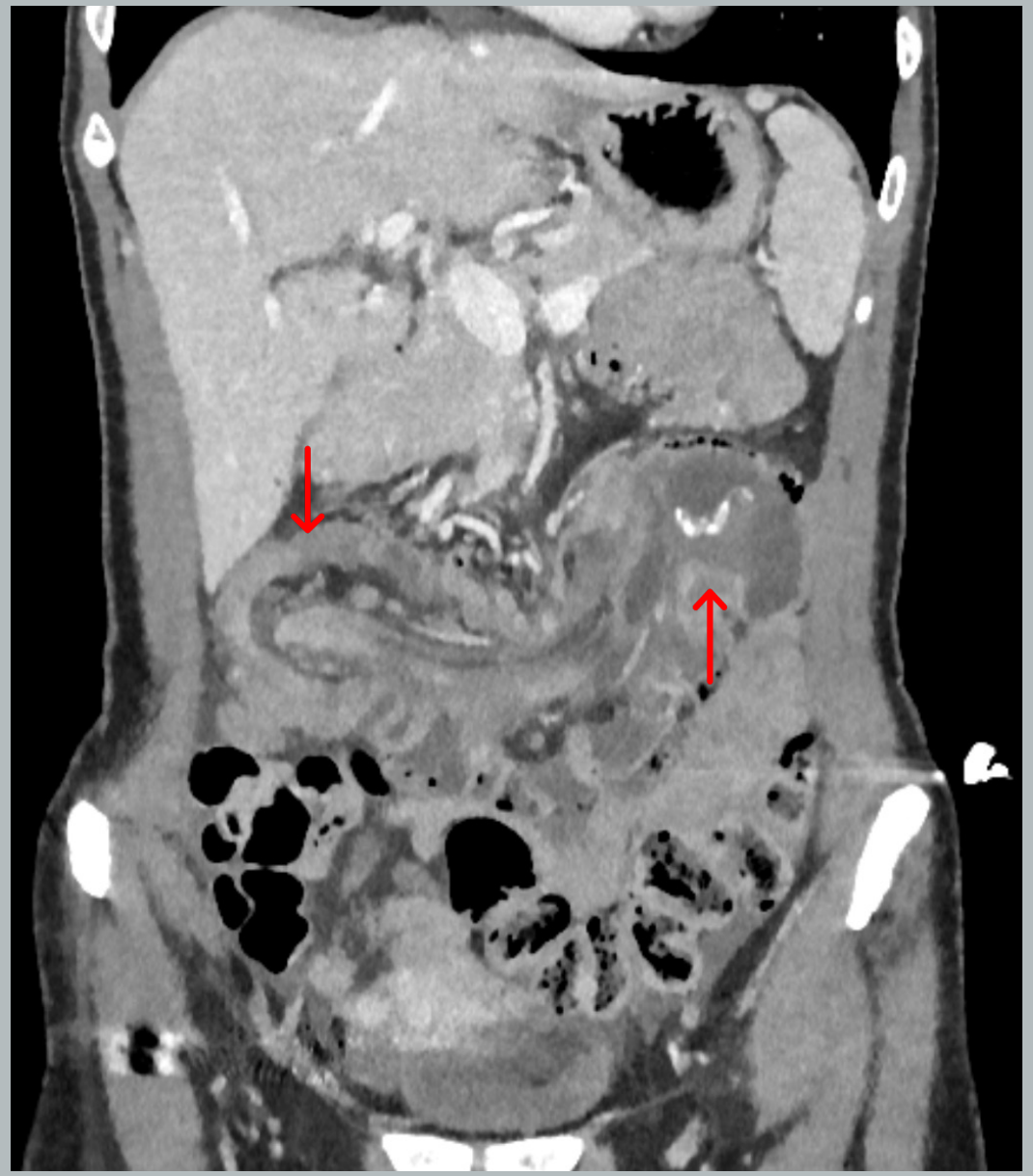
Presented to A&E with progressive severe right iliac fossa pain



Exacerbated by movement and associated with fever and vomiting.

Provisional suspicion was acute appendicitis therefore a CT abdomen and pelvis was requested.

FINDINGS

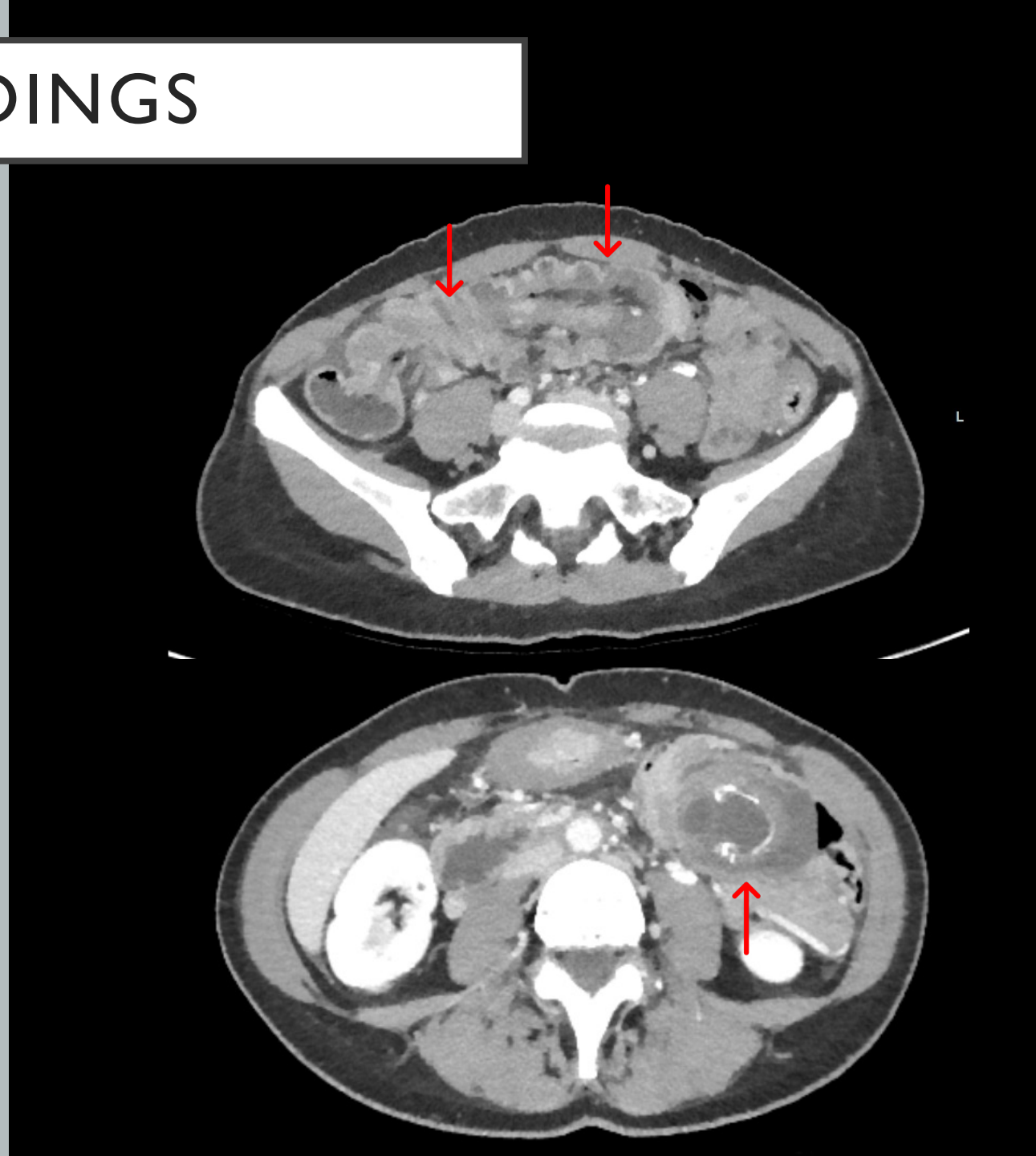


- CT revealed an ileocolic intussusception and bowel obstruction at the level of the splenic flexure.
- A 5cm complex cystic and calcified mass with a dilated appendix measuring 9mm was seen as the lead point.

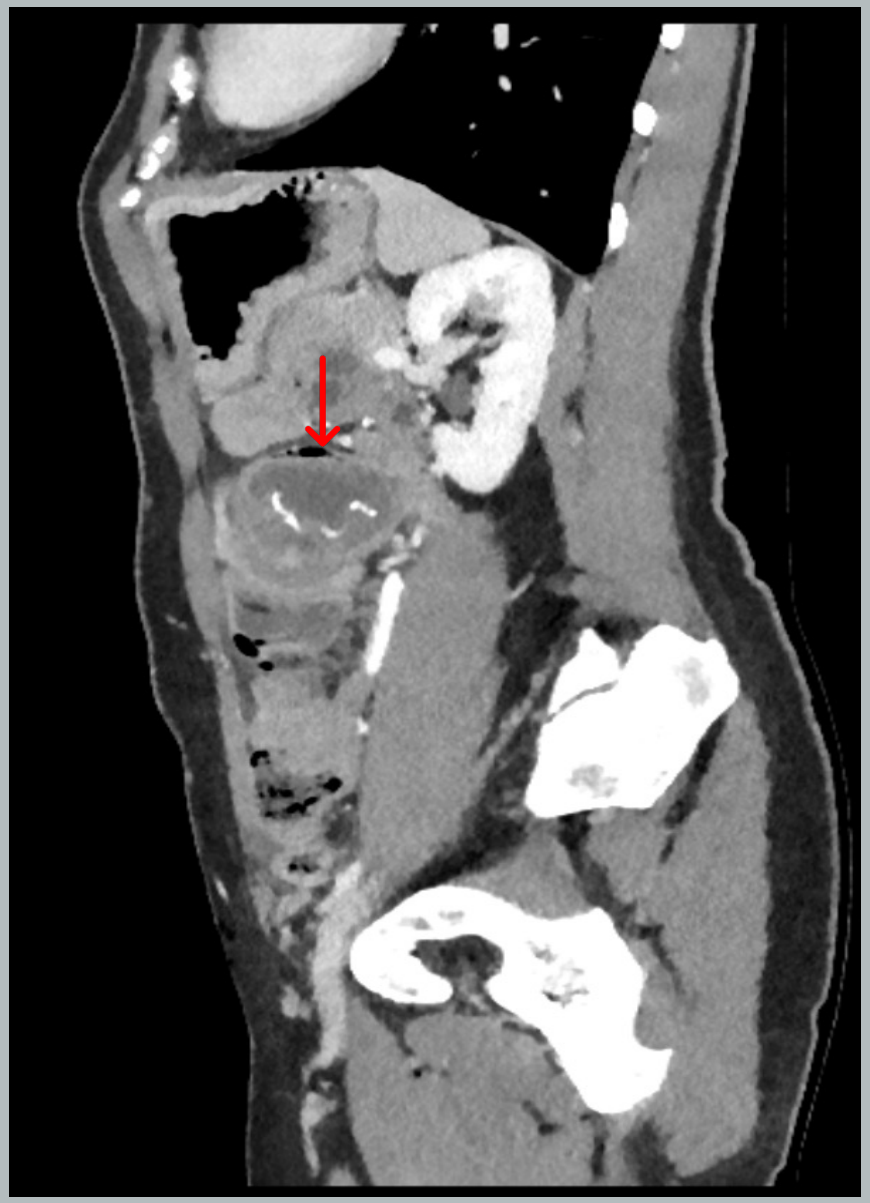
FINDINGS

- Axial CT slices demonstrating the invagination of the caecum and terminal ileum.

- A well circumscribed mass spherical appendiceal mass can be seen containing curvilinear mural calcification thought to be the lead point.



FINDINGS



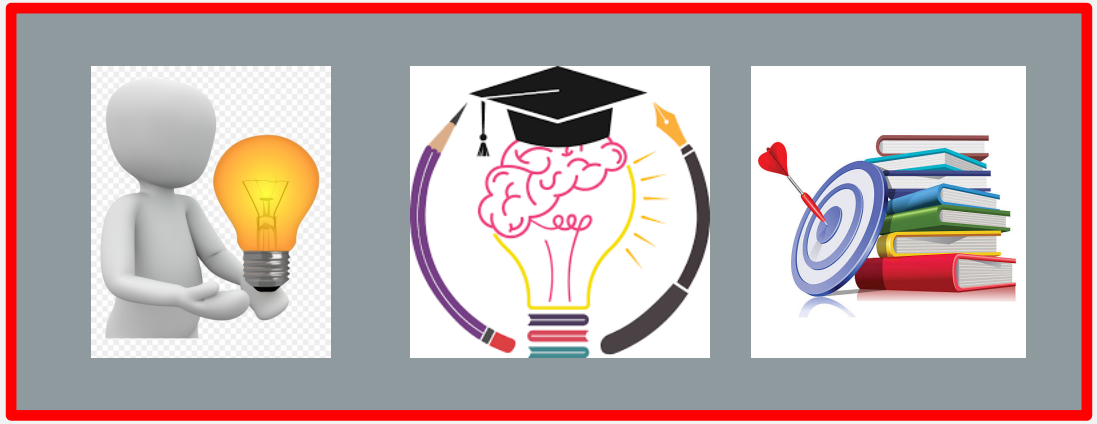
- Coronal CT demonstrating the appendiceal lead point.

DIAGNOSIS AND DISCUSSION

Appendiceal mucocele

- Occurs when obstruction of the lumen leads to mucus accumulation and dilatation of the appendix.
- Spectrum of underlying causes ranging from benign to malignant.
- Curvilinear calcification is only present in 50% of causes.
- **In our patient, a CT scan dated 2020 retrospectively confirmed appendiceal mucocele.**

TAKE HOME MESSAGE



- Only 0.27–0.7% of appendectomies result in appendiceal mucocele (AM), a rare clinical situation.
- Ileocecal/ileocolic intussusception secondary to AM is a very very uncommon condition with only a few case reports published.
- Coronal reformatting always aids in the diagnosis of the lead point and cause.
- Open surgery is the standard of care for AM however laparoscopy is now increasingly considered.
- Right colectomy is needed for ileocolic intussusceptions caused by AM.