



CLINICAL IMAGES

An unusual complication of intestinal amoebiasis

D Steer, D L Clarke, I Buccimazza, S R Thomson

A 39-year-old man presented with a 3-week history suggestive of a small-bowel obstruction. Laparotomy revealed a gangrenous ileocolic intussusception, and a right



Fig. 1. The resected specimen of the intussusception. The closed white arrow shows the invagination point, the open black arrow the caecum and the open white arrow the terminal ileum.

Dion Steer: A senior surgical registrar and keen deep-sea fisherman, currently embroiled in his final exams.

Damian Clarke: Attempts to combine a career as academic surgeon with an encyclopaedic knowledge of American roots music, spaghetti Westerns and sixties garage punk rock.

Ines Buccimazza: Gourmet chef and fine-food critic by night, the doyen of Durban breast surgery by day.

Sandie Thomson: A beachfront professor. Auditioned for the role of William Wallace in the movie epic 'Braveheart', but narrowly lost out to Mel Gibson as it was felt he was too Scottish for an American audience.

All authors are in the Department of Surgery, University of KwaZulu-Natal.

Corresponding author: thomson@ukzn.ac.za

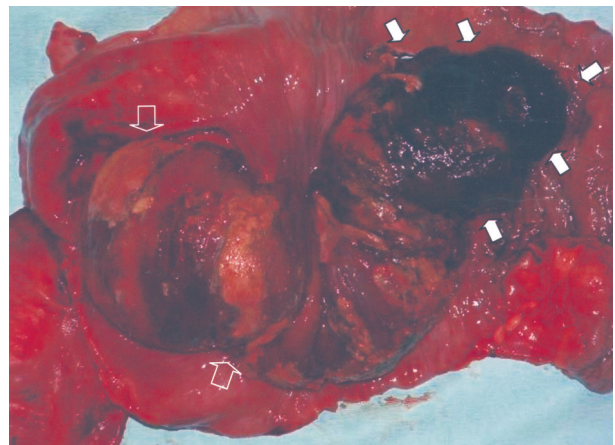


Fig. 2. A close-up of the specimen with the large bowel opened. It demonstrates the intussusceptum which is necrotic at its lead point (closed white arrows) and patchy mucosal necrosis proximally (open white arrows).

hemicolectomy with a primary restorative anastomosis was performed. Figs 1 and 2 demonstrate the resected specimen. Histological examination revealed extensive amoebiasis involving the caecum and intussusceptum. We postulated that the amoebic focus served as a lead point for the development of this intussusception.

Traditionally it was thought that intestinal amoebiasis confined itself to the colon and spared the terminal ileum. Certainly the doyen of the surgical complications of amoebiasis, the late Professor Luvuno, never reported ileal amoebiasis in his extensive reviews on the topic.¹⁻³ Although our institution has subsequently reported on the existence of ileal amoebiasis, amoebiasis as a cause of ileo-colic and colocolic intussusception has only previously been described on the Asian subcontinent.^{4,6} It would appear that ileal amoebiasis as a cause of ileocolic intussusception is something of a unique complication in KwaZulu-Natal, and worthy of documentation.

1. Luvuno FM, Mtshali Z, Baker LW. Toxic dilatation complicating fulminant amoebic colitis. *Br J Surg* 1982; **69**: 56-57.
2. Luvuno FM, Mtshali Z, Baker LW. Vascular occlusion in the pathogenesis of complicated amoebic colitis: evidence for an hypothesis. *Br J Surg* 1985; **72**: 123-127.
3. Luvuno FM. Role of intraoperative prograde colonic lavage and a decompressive loop ileostomy in the management of transmural amoebic colitis. *Br J Surg* 1990; **77**: 156-159.
4. Singh B, Moodley J, Ramdial P, Haffejee AA. Ileal amoebiasis. *J R Coll Surg Edinb* 1997; **42**: 200-202.
5. Patra SB, Giri DD, Shukla GN, Mehta HS. Amoebiasis granuloma – an unusual cause of caeco-colic intussusception. *Postgrad Med J* 1984; **60**: 168-170.
6. Rasaretnam R, Kumarakulasinghe CB, Eaton HL. Tropical intussusception in adults. *Aust N Z J Surg* 1976; **46**(1): 57-63.