SECTION EDITOR: BEVERLY P. WOOD, MD

Radiological Case of the Month

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A 15-YEAR-OLD boy had recurrent colicky lower abdominal pain sometimes accompanied by nonbloody diarrhea. The episodes of pain lasted from hours to several days. His temperature was always normal and he did not vomit. During the last 2 years the patient had gained neither weight nor height. Physical examination revealed lower abdominal tenderness. Results of flexible sigmoidoscopy and biopsy were normal. Computed tomography of the abdomen showed a large lesion in the cecocolic area (**Figure 1** and **Figure 2**). Enteroclysis supported the diagnosis of a large mass in the cecum and ascending colon (**Figure 3**). At colonoscopy the mass was visualized (**Figure 4**).

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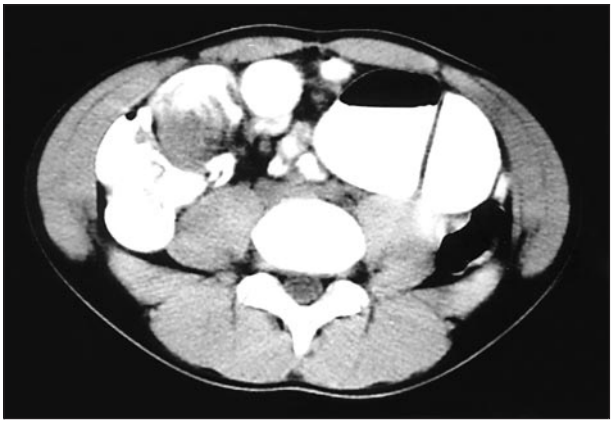

Figure 1.

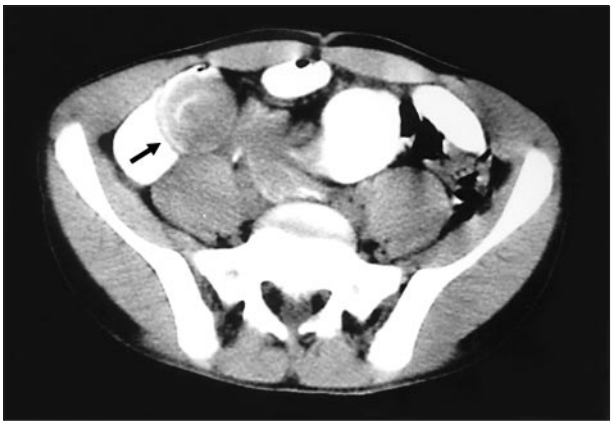

Figure 2.

Figure 3.

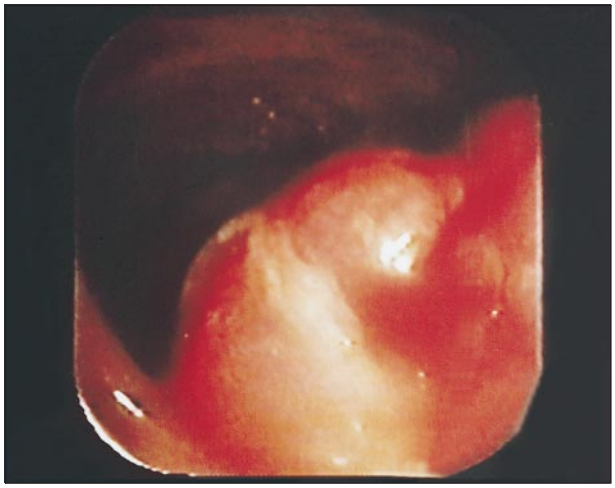

Figure 4.

Denouement and Discussion

Intermittent Ileocolic Intussusception Caused by an Unusual Choristoma

Figure 1. *Computed tomographic scan showed a hyperdense mass occupying the cecum area.*

Figure 2. *Arrow points to target sign suggesting intussusception.*

Figure 3. *The cecal filling defect seen at enteroclysis.*

Figure 4. *Endoscopic view of polypoid cecal lesion that extends into the ascending colon.*

Figure 5. *Operative specimen showing resected ileal segment.*

Figure 6. *Opened specimen shows polypoid lesion with its long pedicule.*

Figure 7. *Gastric heterotopic mucosa and foci of pancreatic tissue.*

At laparotomy an ileocecolic intussusception was reduced and the ileal segment containing a tumor was resected (**Figure 5**). The lead point was a large pedunculated polyp (**Figure 6**). Histologic examination showed that the polyp consisted mainly of heterotopic gastric antral and fundic mucosa and foci of pancreatic tissue (**Figure 7**).

The term *choristoma* is applied to normal tissue in an abnormal location. Heterotopic gastric mucosa occurs anywhere in the gastrointestinal tract.[1,2] Heterotopic gastric tissue in the small intestine is rare and in most cases is associated with a congenital anomaly.[3] Use of imaging and endoscopic examination allows earlier diagnosis.[4,5] A lead point is frequently present in chronic or intermittent intussusception and therefore nonoperative reduction is not indicated. Surgical resection of the involved segment is the preferred treatment, because it corrects the obstruction, avoids recurrence, and excludes the possibility of an associated malignant neoplasm.[6,7]

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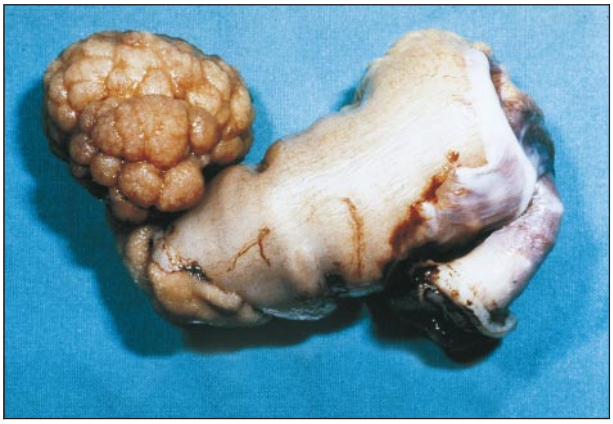

Figure 5.

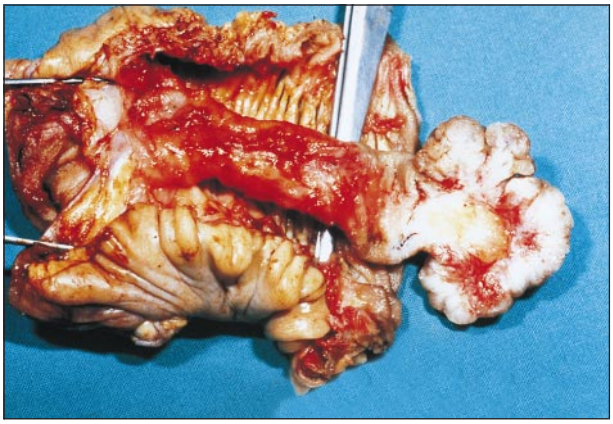

Figure 6.

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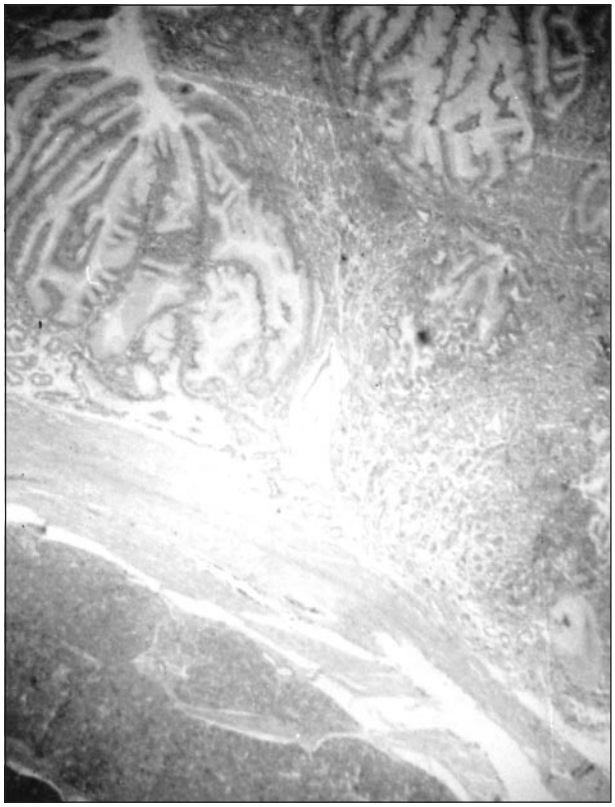

Figure 7.