INTUSSUSCEPTION ENCEPHALOPATHY: A CLINICALLY DECEPTIVE PRESENTATION

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A 7-month-old presented with reduced responsiveness and non-bilious vomiting. On presentation, he was encephalopathic, apyrexial with normal vital signs. Pupils were intermittently miotic and initial abdominal examination was normal. Investigations including blood gas, biochemistry, inflammatory markers, metabolic and toxicology panels were normal. A CT brain scan showed no abnormality.

Abdominal examination 24 hours later elicited a possibility of tenderness.

There were similar two distinct episodes in past where she developed cough, fever and transient difficulty in moving her neck. Both times she recovered fully without any residual symptoms.

Apart from marginally elevated CRP her septic screen was normal. Her persistent symptoms despite intravenous antibiotics prompted CT scan of her neck showing rotatory subluxation of Atlantoaxial joint suggesting Griesel Syndrome while her MRI brain was reported as normal ruling out space occupying lesion.

A week later her serology confirmed the diagnosis of mumps despite of having previous immunization.

She was transferred to tertiary care hospital where a ASPEN neck collar was inserted under sedation with good recovery.

Discussion While approaching patients with acquired torticollis one should be mindful of wide range of differentials like simple trauma to potential space occupying lesion. Blankstein et al describes 61% cases of torticollis being non traumatic in this age group. Underlying pathology could be very diverse ranging from ADEM to Kawasaki disease.

In our case, as patient presented with fever and diffuse neck swelling, we considered only infective etiology initially. But with her persistent symptoms we expanded our differentials and investigated accordingly confirming Griesel syndrome secondary to Mumps. Park et al describes how pharyngovertebral vein act as an septic channel leading to atlanto axial hypereosinemia and intumus present as torticollis.

Conclusion Our case is learning lesson to consider possibility of Mumps as differential diagnosis irrespective of previous immunization status and also to remember comorbidities associated with infective pathology like Griesel syndrome.

Therefore we proceeded with abdominal ultrasound which revealed an evidence of ileocolic intussusception. Initial standard management of ileocolic intussusception was attempted by radiological pneumatic reduction (air enema) which was unsuccessful. Subsequent definitive surgical management achieved by laparotomy and manual reduction successfully released the obstruction.

He recovered uneventfully and underwent usual post-surgical care.

Discussion A recent study showed about 4% of children diagnosed with intussusception had one or more neurological symptoms recorded at presentation. Lethargy was the most frequent, followed by hypotonia, generalised weakness, paroxysmal events, and fluctuating consciousness. One study reported a series of 13 cases of children whom impairment of the mental state preceded the appearance of common gastrointestinal symptoms. Another distinctive feature is the presence of miosis. The aetiology is unclear but there has been hypotheses that this could be caused by the production of endogenous opioid in response to stress and pain.

Conclusion This case illustrates a rare occasion of intussusception presenting as an acute encephalopathy in the absence of typical signs of bowel obstruction.

Although uncommon, the recognition of this possibility should be entertained, particularly in an unexplained encephalopathy.