

Case Report

Jejunojejunal intussusception caused by a jejunal lipoma in a 92-year-old patient: CT diagnosis

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Received: 08 July 2026

Accepted: 14 August 2026

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ABSTRACT

Background: Adult intussusception is an uncommon cause of bowel obstruction and is usually associated with an identifiable pathological lead point. Among benign etiologies, submucosal lipomas of the small bowel are rare but may induce intussusception when they reach a significant size. We report the case of a 92-year-old man who presented with acute abdominal pain and subocclusive syndrome. Because of his history of bilateral inguinal hernias, strangulated hernia was initially suspected. Contrast-enhanced CT instead demonstrated an uncomplicated jejunojejunal intussusception caused by a 46-mm submucosal jejunal lipoma, with no evidence of bowel ischemia. Conservative management resulted in a favorable clinical outcome. This case highlights the pivotal role of CT in establishing the diagnosis, identifying the benign lead point, excluding ischemic complications, and guiding appropriate management in elderly patients presenting with acute abdominal pain.

Keywords: Adult intussusception, Jejunal lipoma, Small bowel, Computed tomography

INTRODUCTION

Adult small-bowel intussusception is an uncommon entity, representing 1-5% of bowel obstructions.¹ Unlike pediatric cases, which are mainly idiopathic, adult intussusception is associated with an identifiable lead point in up to 90% of cases, most often a benign or malignant tumor. Submucosal lipomas are among the most frequently reported benign lesions implicated in adult intussusception, although they remain rare and often asymptomatic until they reach a significant size.

Previous publications describe jejunal lipomas as typical lead points responsible for jejunojejunal intussusception, frequently diagnosed on computed tomography (CT).^{2,3} Symptomatic small-bowel lipomas usually exceed 2 cm and frequently present with intussusception.¹

We report a rare case of uncomplicated jejunojejunal intussusception caused by a large submucosal lipoma in a 92-year-old patient. This report emphasizes the characteristic CT findings that enabled prompt diagnosis, exclusion of bowel ischemia, and selection of conservative management.

CASE REPORT

A 92-year-old man with a medical history of cholecystectomy and bilateral inguino-scrotal hernias presented with acute abdominal pain. He also reported a subocclusive syndrome, with absence of stool and flatus for two days, without abdominal distension. Because of his known hernias and the sudden onset of symptoms, strangulated hernia was initially suspected. On examination, the abdomen was soft with mild focal tenderness. Both hernias were visible, but no reduction

maneuver was attempted due to the patient's pain and advanced age, and incarceration could not be excluded. Vital signs and laboratory tests, including inflammatory markers, were normal. Given the potential risk of a strangulated inguinal hernia, an urgent contrast-enhanced CT scan was performed. The CT scan demonstrated no incarcerated hernia. Instead, it revealed a right paraumbilical jejunojejunal intussusception measuring approximately 5.5 cm in length characterized by a typical "sandwich sign" (Figure 1).

Coronal reconstruction confirmed the diagnosis by demonstrating a well-defined "target sign," consistent with the telescoping of bowel segments (Figure 2).

A well-circumscribed intraluminal fat-density lesion measuring 46 mm was identified at the lead point. The lesion demonstrated homogeneous fat attenuation with smooth margins and no internal septations or soft-tissue components, imaging features strongly suggestive of a benign submucosal lipoma (Figure 3).

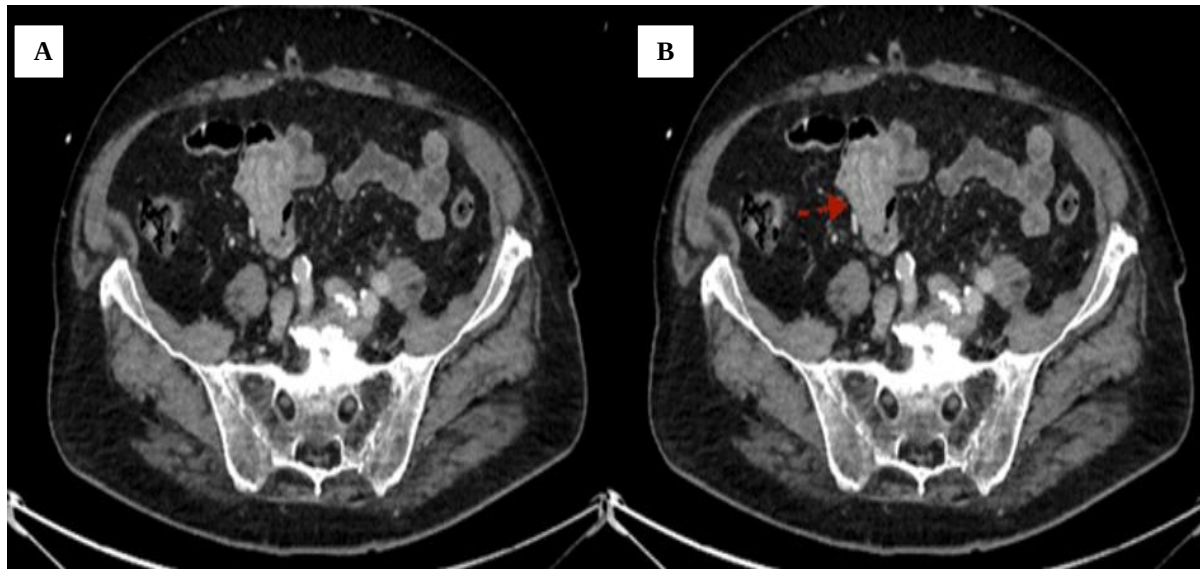


Figure 1: Jejunojejunal Intussusception with Sandwich Sign on Axial CT. Axial contrast-enhanced CT images showing a right paraumbilical jejunojejunal intussusception with the classic "sandwich sign," characterized by concentric bowel layers surrounding invaginated mesenteric fat and vessels. (A) Unannotated image and (B) the "sandwich sign" is indicated by a red arrow.

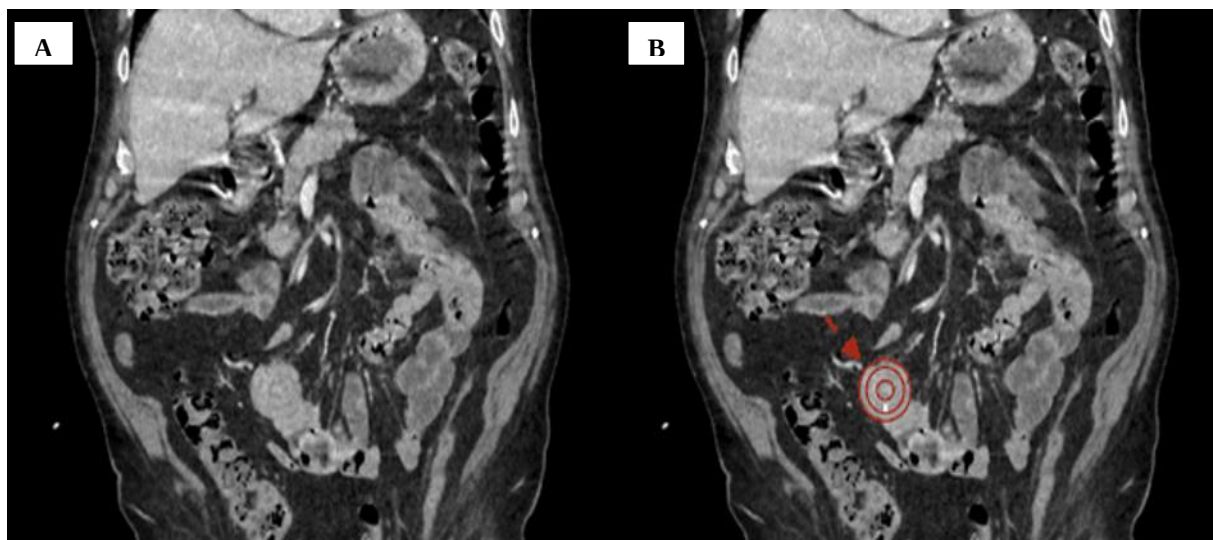


Figure 2: Target sign on coronal CT reconstruction. Coronal CT reconstruction demonstrating the characteristic "target sign," with concentric alternating soft-tissue and fat-density rings corresponding to telescoped bowel segments. (A) Unannotated image and (B) the target sign is illustrated by concentric rings and indicated by a red arrow.

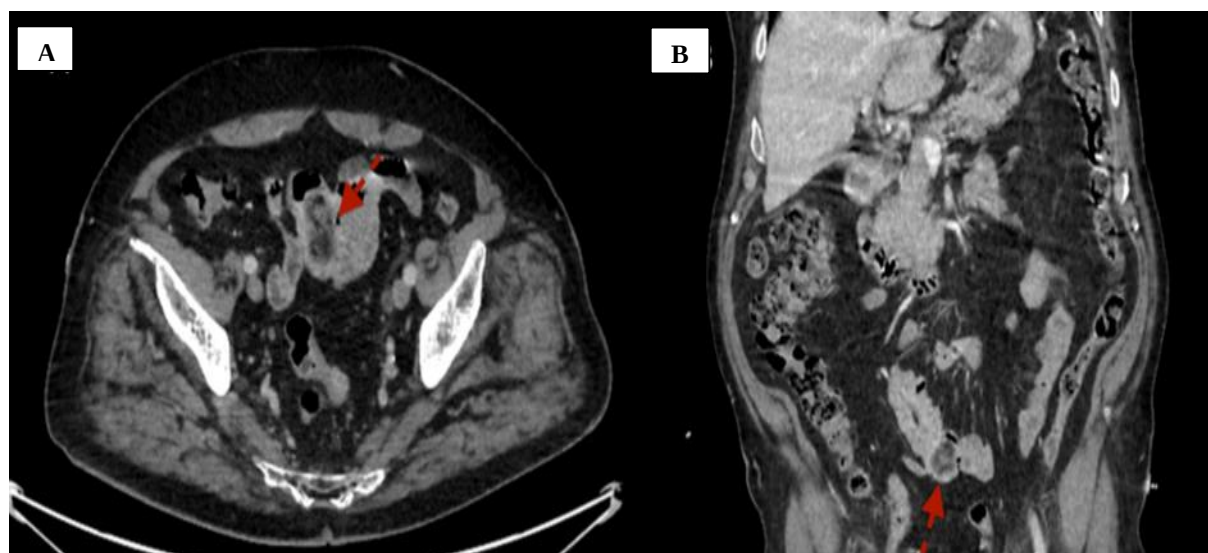


Figure 3: CT Identification of the Jejunal lipoma serving as the lead point of intussusception. (A) Axial CT image showing a well-circumscribed intraluminal fat-density lesion (arrow), consistent with a jejunal lipoma and (B) coronal reconstruction confirming homogeneous fat attenuation and smooth margins (arrow).

Importantly, there were no signs of bowel ischemia, including no mural thickening, no reduced enhancement, no pneumatosis intestinalis, and no mesenteric venous congestion. These findings supported an uncomplicated jejunojejunal intussusception secondary to a jejunal lipoma, and conservative management was therefore adopted, with favorable clinical evolution.

DISCUSSION

Small-bowel intussusception in adults is rare and differs significantly from the pediatric form, which is usually idiopathic. In adults, a structural lead point is identified in up to 90% of cases, most commonly a benign or malignant tumor. Submucosal lipomas represent one of the most frequent benign etiologies and may become symptomatic when their size exceeds 2-3 cm, increasing the risk of acting as a traction point for intussusception.^{1,2}

The present case is remarkable because of the patient's advanced age and the absence of ischemic complications despite a relatively large lead-point lesion. Although most reported adult intussusceptions caused by jejunal lipomas are managed surgically, conservative treatment may be appropriate in carefully selected patients when CT demonstrates a benign fat-density lesion, preserved bowel wall enhancement, and no imaging signs of vascular compromise. This approach may be particularly valuable in elderly or frail patients in whom operative risk is substantial. In elderly patients presenting with acute abdominal pain, strangulated inguinal hernia is a major diagnostic concern, particularly in individuals with known hernias. In this case, the presence of bilateral inguino-scrotal hernias and sudden-onset pain initially raised suspicion of hernia strangulation. Because clinical examination alone is often insufficient to exclude

incarceration in this population, urgent CT imaging is recommended. CT is crucial not only to rule out hernia-related complications but also to identify alternative diagnoses, as illustrated in this case and supported by the literature.²⁻⁴

CT is the modality of choice for diagnosing adult intussusception. The classic "target," "sausage," or "sandwich" configurations accurately depict the telescoping bowel loops and the invaginated mesenteric fat. When a homogeneous fat-density mass is present at the apex, the diagnosis of lipoma is highly reliable. A systematic review emphasizes the ease with which lipomas can be identified radiologically due to their characteristic attenuation and well-defined margins.¹

The differential diagnosis for a fat-containing intraluminal lesion includes atypical lipomatous tumors or well-differentiated liposarcomas. These lesions tend to exhibit internal septations, heterogeneous density, or irregular borders.⁴ None of these features were observed in this case, supporting the benign nature of the lesion.

Most adult intussusceptions with an identifiable lead point are traditionally managed surgically due to the risk of an underlying pathological lesion. Surgical resection is generally recommended, particularly in cases associated with bowel obstruction, ischemia, or suspicion of malignancy. Operative management in similar cases has been reported in the literature.^{5,6} However, non-operative management may be considered in selected situations, particularly in frail or elderly patients when imaging shows no vascular compromise and symptoms improve spontaneously. Unlike most previously reported cases, which underwent surgical resection, our 92-year-old

patient was successfully managed conservatively owing to the absence of CT signs of ischemia or bowel compromise.

Our case illustrates the essential role of CT not only in confirming adult intussusception but also in accurately characterizing its underlying cause. Recognition of a well-circumscribed fat-density lesion with typical imaging features allowed confident diagnosis of a benign jejunal lipoma while excluding imaging findings suggestive of malignancy or bowel ischemia. In addition, CT ruled out the initially suspected incarcerated inguinal hernia, thereby preventing inappropriate management. This case further supports the value of CT as the cornerstone imaging modality for therapeutic decision-making in adult intussusception.

CONCLUSION

Jejunojejunal intussusception secondary to a jejunal lipoma is an uncommon cause of acute abdominal pain in adults. Contrast-enhanced CT plays a pivotal role by confirming the diagnosis, identifying the benign lead point, and excluding ischemic complications. In carefully selected elderly patients with uncomplicated intussusception and reassuring CT findings, conservative management may represent a safe therapeutic alternative.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Obilat S, Harras YE, Lasri L, Imrani K, Nassar I. Jejunojejunal intussusception caused by a jejunal lipoma in a 92-year-old patient: CT diagnosis. *Int J Res Med Sci* 2026;14:4025-8.