Case Description: A 16 year old female presented with limb swelling, numbness, facial puffiness, intermittent abdominal pain, and arthralgia for 2 weeks. The abdominal pain worsened after meals, and she also complained of nausea, vomiting, and two episodes of bloody diarrhoea. Examination revealed signs of ulnar nerve palsy and palpable purpuric rashes on the lower limbs. Blood tests showed eosinophilia with an absolute count of 2140, elevated CRP and thrombocytosis. Skin biopsy confirmed eosinophilic small-vessel vasculitis. Serology revealed positive p-ANCA, elevated rheumatoid factor, and weakly positive DAT. CT angiogram suggested vasculitis involving coeliac axis and superior mesenteric artery. Nerve conduction studies supported mononeuritis multiplex. The patient was diagnosed with EGPA and treated with intravenous methylprednisolone, followed by oral corticosteroids. The patient showed marked clinical improvement with corticosteroid therapy and was asymptomatic at discharge. She was discharged on oral prednisolone and scheduled for outpatient follow-up with an abdominal ultrasound planned.

Discussion: The clinical features of EGPA were variable, with some manifestations preceding others, leading to a delay in diagnosis until the later stages. This case demonstrates a rare, atypical presentation of EGPA in an adolescent without a history of asthma or atopy. Hypereosinophilia, elevated inflammatory markers, a positive p-ANCA, and CT angiogram findings helped establish the diagnosis, even in the presence of a wide range of symptoms.

Conclusion: Multisystem involvement, including gastrointestinal symptoms, along with eosinophilia and vasculitic features, guided the diagnosis. This case highlights the importance of considering EGPA in patients with unexplained systemic inflammation and eosinophilia, even in the absence of classical allergic features, and describes a rare gastrointestinal presentation of EGPA.

PP 36

Recurrent Intussusception Caused by Buried Viable Appendix: A Rare Case Study

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Introduction: Intussusception is a common cause of intestinal obstruction in infants and young children, but recurrence is relatively uncommon (about 10%). Pathological lead points are identified in roughly 10% of cases and are more frequent in older children, rising to nearly 57% beyond 4 years of age. Among various lead points, Meckel's diverticulum is the most frequent; the appendix acting as a lead point is extremely rare, estimated at approximately 0.01% of appendectomy specimens. This report describes an unusual case where a previously inverted (buried) yet viable appendix became the lead point for recurrent intussusception.

Case Presentation: A 4-year 7 month old boy presented with recurrent abdominal pain and vomiting. He had multiple previous episodes of ileocecal intussusception since infancy, treated surgically with open reduction and inversion (burial) of the appendix rather than appendectomy. On the current admission, ultrasound confirmed ileocecal intussusception. Laparotomy revealed the inverted, viable appendix forming the lead point. The intussusception was reduced, and appendectomy performed. The child recovered uneventfully, and no further recurrences occurred on follow-up for last 5 years.

Discussion: Recurrent intussusception always warrants evaluation for pathological lead points. While buried appendix is occasionally used as a surgical technique, this case demonstrates that a viable inverted appendix can itself act as a pathological lead point. Awareness of this rare phenomenon is important, as failure to remove the appendix during initial surgery may predispose to recurrence. Appendectomy in such situations prevents future episodes and associated morbidity.

Conclusion: This case highlights that even a buried, viable appendix can serve as a lead point for intussusception. Definitive appendectomy should be considered in recurrent cases to eliminate this rare but significant cause. Although inversion (burial) of the appendix was historically practiced, it is now considered largely obsolete in

modern paediatric surgery, with appendectomy being the standard of care to avoid such complications.

PP 37

Jejunal Lymphatic Malformation Presenting as Acute Intestinal Obstruction in an Infant: A Case Report

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Introduction: Lymphatic malformations are rare congenital defects of the lymphatic system, most frequently observed in the cervical (around 75%) and axillary (about 20%) regions. Abdominal lymphatic malformations represent only 5–10% of all cases, with involvement of the small intestine being extremely uncommon—estimated at less than 1% worldwide. These lesions can remain silent or present with serious complications such as volvulus, intussusception, bleeding, or intestinal obstruction.

Case Presentation: A 5 month old girl was admitted with a 24 hour history of persistent vomiting, progressive abdominal distension, and absolute constipation. Physical examination revealed a soft but distended abdomen. Ultrasonography showed a multiloculated cystic structure in the left lower quadrant with minimal free fluid, initially thought to be of ovarian origin.

Diagnostic laparoscopy was undertaken, which identified the cyst as arising from the jejunum rather than the adnexa. Owing to the extent of involvement and need for definitive treatment, the procedure was converted to an open approach. A 5 cm segment of jejunum containing a circumferential cystic lesion infiltrating all layers of the bowel wall was resected, followed by end to end anastomosis. The postoperative course was smooth, with early return of bowel function. Examination confirmed a lymphatic malformation characterized by dilated lymphatic channels extending