Intussusception Complicating Intestinal Intubation with a Long Cantor Tube:
Report of Four Cases*

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In the past decade, increasing numbers of reports regarding the use of long intestinal tubes and their complications have appeared in the literature. As their use becomes more acceptable as the prime modality in the treatment of nonstrangulating small-bowel obstruction, as well as their use prophylactically in elective colonic surgery, it can be expected that the occurrence of small-bowel intussusception will be recognized and documented more frequently.

When used prophylactically in colonic surgery, the Cantor tube not only acts by decompressing the bowel prior to operation, but facilitates the use of oral

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preoperative bowel preparation with antibiotics. It may convert a partially or totally obstructed bowel into an elective case. It also improves the exposure during laparotomy. Postoperatively, it combats recurrent and partial small-intestinal obstruction.

On the colon and rectal service at Muhlenberg Hospital, the Cantor tube is used regularly in obstructive and elective cases. During the past 15 years more than 2,000 colonic resections have been performed. We were able to collect reports of four cases of intussusception caused by the Cantor tube that necessitated laparotomy. Sower and Wratten, in a review, collected 19 cases from 1945 to 1965. Ginzburg and Friedman were able to collect eight cases in their personal series reported in 1974.

Report of Four Cases

Patient 1. A 65-year-old woman who had undergone a Hartmann procedure and left salpingo-oophorectomy for an obstructing carcinoma of the sigmoid colon was readmitted for resection and closure of her colostomy. A Cantor tube was introduced into the small intestine on the day before operation. Resection of the descending colon, colostomy, and proximal rectum was performed with a transverse colon-to-rectum anastomosis. The postoperative course was uneventful until the seventh postoperative day, when the patient started to vomit bilious material. An obstructive series at this time was not abnormal (Fig. 1). The patient continued to vomit in spite of the insertion of a nasogastric tube. The Cantor tube was removed, but vomiting persisted. An upper GI series showed obstruction at the junction of the third and fourth portions of the duodenum near the ligament of Treitz (Fig. 2). The possibility of a superior-mesenteric-artery syndrome was entertained. Total parenteral hyperalimentation was started. By the sixteenth postoperative day the patient's bowels were moving. The nasogastric tube was removed. However, soon after this, sporadic vomiting recurred. The abdomen was re-explored on the nineteenth postoperative day. An antegrade jejuno-jejunal intussusception was found and reduced. The postoperative course was uneventful. The patient has remained well.

Patient 2. A 79-year-old woman was admitted to Muhlenberg Hospital was an early large-intestinal obstruction as demonstrated on barium-enema examination the day before admission. The patient was given liquids, Fleet's Phospho-soda, and gentle tap-water enemas, with resolution of the obstruction. A Cantor tube had been passed and antibiotic bowel preparation initiated. Sigmoideal resection was performed for obstructing diverticular disease. Postoperatively, the patient did well. By the seventh postoperative day she was passing flatus. She tolerated oral fluids, and the Cantor tube was removed the following day.