

Submucosal lipoma located on the ascending colon

Çıkan kolon yerleşimli submukozal lipom

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Received/Accepted: November 10, 2015/December 05, 2015

Conflict of interest: There is not a conflict of interest.

Dear Editor,

A 68 years old female patient applied to the General Surgery clinic with complaints of pain in the right lower quadrant and abdominal distention. Her vitals and blood tests revealed no abnormality. The contrasted abdominal tomography was interpreted as a soft tissue mass containing fat density with smooth margins, adjacent to the ileocecal valve and having a diameter of approximately 3 cm. In her surgery, the mass was excised by a 5 cm incision 5 cm distal to the cecal region on the wall adjacent to the mass. The incision was closed using a linear stapler.

Colonic lipoma was first defined in 1757 by Bauer et al.¹. Lipomas are benign tumors of mesenchymal origin. They are rarely observed in the gastrointestinal system. Although being rare, they are the most common type of non-epithelial benign tumors^{2,3}. The incidence has been reported as 15-4.4%⁴. Lipomas represent 5% of all gastrointestinal tumors and 10% of the benign gastrointestinal tumors⁵⁻⁶. In the gastrointestinal system, 70% of the lipomas are located at the large bowel while other sites include the small bowel (25%) and stomach (5%)⁷. Frequently, 90% of the lipomas are submucosal and 10% are subserosal⁸. In terms of gender distribution, it has been reported that lipomas are more frequent in women and have a peak incidence in the fifth and sixth decades of life⁵.

⁹. A great majority of bowel lipomas are asymptomatic. It is generally accepted that submucosal lipomas having a diameter of 2 cm or greater are symptomatic^{7,8}.

The most common symptoms are abdominal pain (68%), intussusception (44%), hemorrhage (29%), vomiting (24%) and obstructive symptoms (18%). Rarely, the patients may apply with a complaint of extraction of a lump of hemorrhagic tissues due to self-amputation of the lesion¹⁰. Macroscopically, lipomas are well-circumscribed masses in bright yellow color, covered with intact intestinal mucosa, having a diameter of 1-30 cm and made up of fat tissue. Widespread necrosis and haemorrhage and grey-green tissue colour can be observed in specimens belonging to the cases developing ischemia due to invagination and self-amputation.

Microscopically, lipomas are composed of mature adipocytes arranged in lobules surrounded by a fibrous capsule. In adipocytes, there is no evidence of atypia or malignancy. In the literature, cases having concomitant intestinal lipoma and adenocarcinoma have been reported¹¹. Large lipomas or those causing complications should be removed surgically. From segmental colonic resection by laparotomy to enucleation of the lipoma by colonoscopy, many methods have been defined in the surgical treatment.

In surgery, lipomectomy together with

colostomy, limited resection, segmental resection in case of invagination due to lipoma, infarct and necrosis or hemicolectomy should be performed. Wide resections should be avoided upon proper colonoscopic and radiological evaluation.

Lipomas causing complications can be misdiagnosed as premalign lesions and carcinomas. These cases should be treated by surgery and findings during laparotomy should be taken into account while deciding on the surgery type.



Figure 1: CT scan of the abdomen showing the lesion.



Figure 2: Macroscopic picture of the resected specimen.

REFERENCES

1. Haller JD, Roberts TW: Lipomas of the colon: A clinicopathologic study of 20 cases. *Surgery* 1964; 55:773-781
2. Rogy MA, Mirza D, Berlakovich G, Winkelbauer F, Rauhs R. Submucous large-bowel lipomas-presentation and management. An 18-year study. *Eur J Surg* 1991; 157: 51-5.
3. Bardaji M, Roset F, Camps R, Sant F, Fernandez-Layos MJ. Symptomatic colonic lipoma: differential diagnosis of large bowel tumors. *Int J Colorectal Dis* 1998; 13: 1-2.
4. Chung YF, Ho YN, Nyam DC, Leopng AF, Seow-Choen F: Management of colonic lipomas. *Aust N Z J Surg* 1998; 68: 133.
5. Krasniqi AS, Hamza AR, Salihu LM. Compound double ileoileal and ileoceccocolic intussusception caused by lipoma of the ileum in an adult patient: A case report. *J Med Case Reports* 2011; 5: 452.
6. Balik AA, Ozturk G, Aydinli B. Intussusception in adults. *Acta Chir Belg* 2006; 106: 409-12.
7. Minaya Bravo AM, Vera MC, Noguerales FF. Ileocolic intussusception due to giant ileal lipoma: Vol. 24, No.1 Barsak lipomu: Olgu sunumu 23 © TKRCD 2014 Review of literature and report of a case. *Int J Surg Case Rep* 2012; 3: 382-4.
8. Aytaç B, Yerci Ö, Gürel S. Colonic lipomas mimicking colon cancer. *Turk Patoloji Derg* 2010; 26: 196-9.
9. Rogy MA, Mirza D, Berlakovich G. Submucous large bowel lipomas presentation and management: an 18 year study. *Eur J Surg* 1991; 157: 51-5.
10. Radhi JM: Lipoma of the colon: Self Amputation. *Am J Gastroenterol* 1993; 88: 1981-2.
11. Di Saverio S, Tugnoli G, Ansaloni L. Concomitant intestinal obstruction: a misleading diagnostic pitfall. *BMJ Case Rep* 2010;12: 2010.