



“Colonic Lipoma: Incidental and Urgent Management, Report of Two Cases and Review of the Literature”

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Introduction

Lipomas are benign tumors rarely found in the digestive tract, particularly rare in the colon [1], that were first described by Bauer in 1757 as an unusual cause of intussusception in the adult. Lipomas are most often small, asymptomatic and identified as incidental findings during colonoscopy [2]. Nonetheless, up to 25% are symptomatic in the form of abdominal pain, bleeding, diarrhea or intussusception [3]. Ninety percent of lipomas in the colon are located at the submucosal layer, with only few originating in the subserosa [4]. When lipomas present as bowel obstruction, they are often pedunculated and large [5].

Clinical Case 1

A previously healthy 33-year-old male recently diagnosed by colonoscopy of a colonic submucosal lesion vs extrinsic compression of the hepatic colonic flexure, presented with abdominal pain, diarrhea and rectorrhagia for a month. He complained of worsening symptoms in the previous hours, associated to vomiting. On examination, the patient was afebrile and presented with a distended abdomen that was painful upon deep palpation, but had no signs of rigidity or peritoneal inflammation. Lab work-up showed discrete leukocytosis.

An urgent CT showed a colo-colonic intestinal invagination and a 3,7 cm mass compatible with a lipoma at the hepatic flexure, which served as the head of the intussusception. There was also post-stenotic dilation (Figure 1).

With these findings, the patient underwent an exploratory laparoscopy that identified a colo-colonic intussusception of the transverse colon (Figure 1) associated to a short right colon, for which he received a laparoscopic right hemicolectomy.

The patient's postoperative course was uneventful. The pathological report revealed intussusception caused by the lipoma, with no evidence of malignancy.

Clinical Case 2

A 51-year-old male with prior history of obesity and type II diabetes sought consultation for abdominal pain and rectorrhagia. Colonoscopy show a distal sigmoid tumor, approximately 18 cm from the anal margin and a pedunculated mass approximately 40 cm from the anal margin, compatible with lipoma. With these findings, the patient was taken to laparoscopic oncological sigmoidectomy with complete mobilization of the splenic flexure in order to fully resect the area containing the lipoma (Figure 2). The postoperative course was uneventful, except for Central venous catheter-related bacteremia

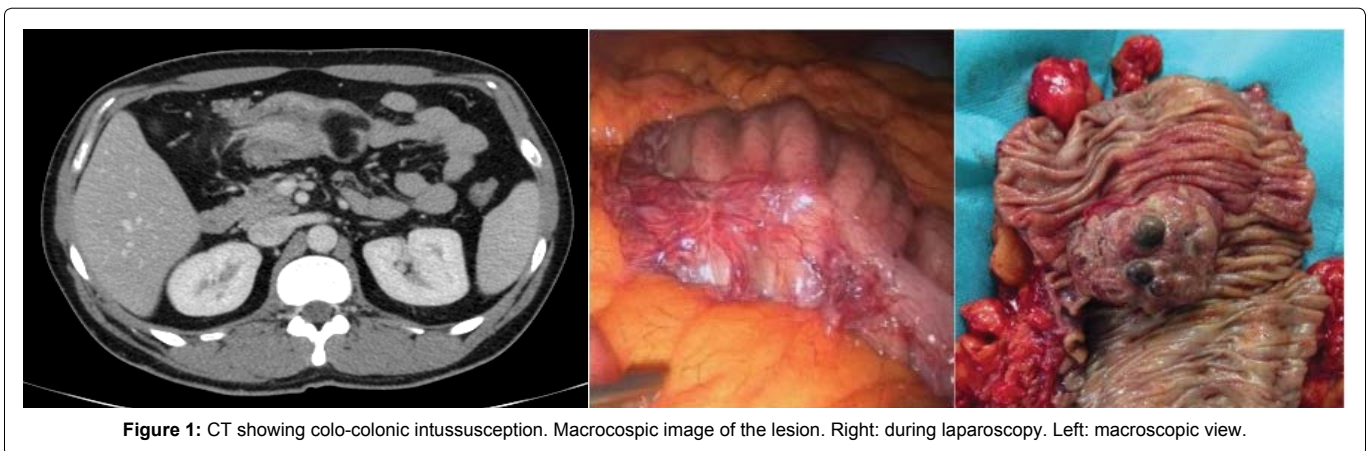


Figure 1: CT showing colo-colonic intussusception. Macroscopic image of the lesion. Right: during laparoscopy. Left: macroscopic view.

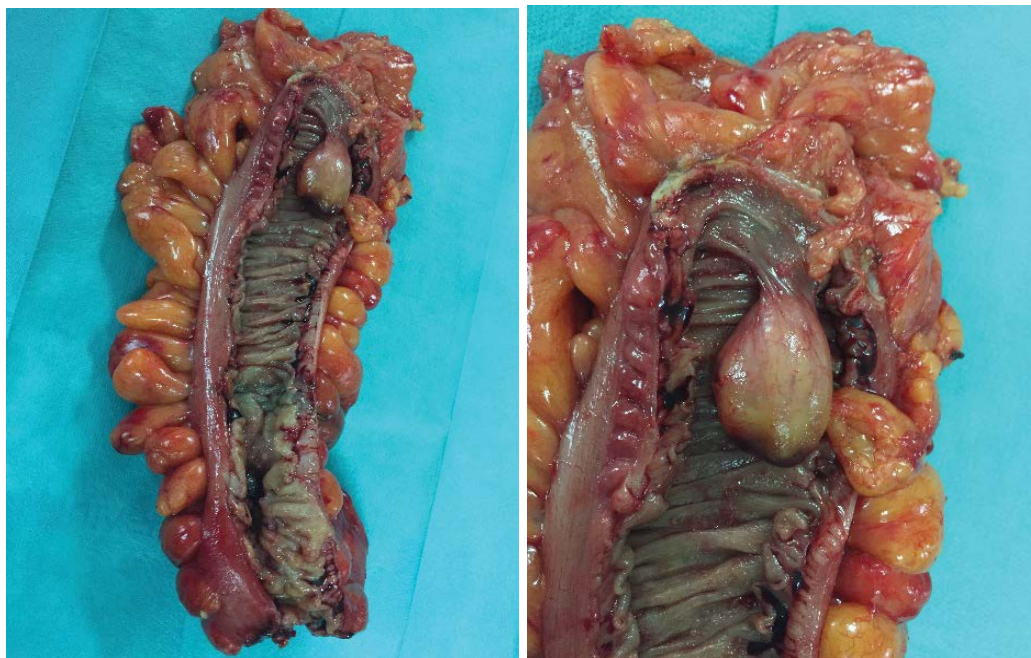


Figure 2: Adenocarcinoma with proximal lipoma.

that was properly treated with antibiotics. The pathological report revealed a T3N1 (1/31) adenocarcinoma and a pedunculated lipoma without signs of dysplasia.

Discussion

Colonic lipomas are rare benign tumors of the digestive tract. Their incidence is estimated between 0.035 and 4.4%, peaking between ages fifty and sixty, with a female preponderance. They are usually solitary and most frequently occur in the ileocecal area [4].

Colonic intussusception is a rare form of presentation for this benign tumor; however, as 64% of neoplasias causing intussusception are malignant, we recommend surgery as the initial approach. The clinical picture of abdominal pain, obstructive symptoms and rectorrhagia or melena is unspecific, thus a high index of suspicion is needed for the diagnosis [6], and abdominal CT is the imaging technique with greatest diagnostic yield in these cases. Colonoscopy is useful for locating the injury or evaluating the degree of obstruction, however, since lipomas are usually submucosal injuries, they are very difficult to characterize by this technique alone. Other tests such as abdominal ultrasound or X-ray are less sensitive. Laparoscopy can be therapeutic, but to date there are no defined diagnostic or treatment patterns [7].

Intraoperative frozen section biopsies may be useful for obtaining a faster diagnosis and thus allow more limited resections [8]. The laparoscopic removal of these lesions, guided or not by endoscopy, may be very complex in urgent situations [3].

Conservative management and radiological follow-up may be considered in case of an incidental finding of intussusception in the absence of clinical repercussion and with a clear cause; however, in most cases, surgical resection of the affected area allows for the prevention of recurrences of the clinical presentation in the case of benign injuries and a curative treatment in malignant lesions [9]. This is especially true in cases requiring urgent intervention. There are reports in the literature of elective endoscopic resections of lesions up to 5 cm, but is not recommended due to the high risk of perforation [10].

Conclusion

Resection of lipomas must be considered in the management of the patients with this pathology who require abdominal surgery. Colo-colonic invagination is a pathology requiring surgical treatment

that must be considered in the differential diagnosis of acute intestinal obstruction.

References

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