

# Giant Colonic Lipoma Presenting with Intermittent Intestinal Obstruction

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## ABSTRACT

Lipomas of gastrointestinal (GI) tract are the common benign tumours. They are usually small and asymptomatic; however, large colonic lipoma is a rare tumour and may cause intestinal obstruction. A similar rare case of large lipoma, treated with laparoscopic right hemicolectomy, is reported here.

**Key words:** *Lipoma. Colon. Intestinal obstruction.*

## INTRODUCTION

Lipomas of the gastrointestinal (GI) tract are rare benign tumours and were first described by Bauer in 1957. They are the second most common benign colonic tumours following benign adenomatous polyps.

The most common site for lipoma in GI tract is caecum, which is followed by ascending and sigmoid colon. The size of the lipomas vary between 2 mm upto 30 cm, however, they rarely cause symptoms if less than 2 cm and usually discovered incidentally on CT scans or during colonoscopy. The term 'giant lipoma' has been applied to lesions more than 5 cm in diameter. These large lesions can become lobulated or pedunculated,<sup>1</sup> and may present with abdominal pain, vomiting, intestinal obstruction, intussusception, ulceration and haemorrhage.<sup>1-3</sup> They are the most common benign tumours that can cause intussusception in adults. We present here the case of a giant lipoma presenting with abdominal pain, vomiting and intestinal obstruction.

## CASE REPORT

A 52 years old female presented with colicky upper abdominal pain. It was associated with bloating, nausea, intermittent vomiting, and episodes of constipation for 2 – 3 days since 4 weeks. This was not associated with anaemia, diarrhoea, per rectal bleeding, weight loss and loss of appetite. General physical and abdominal examinations were normal. Full blood count, biochemical investigations and faecal occult blood were unremarkable. A CT scan of abdomen demonstrated a well circumscribed 6 x 4 cm mass at the hepatic flexure causing partial bowel obstruction and no

evidence of regional lymphadenopathy. The findings were suggestive of a giant lipoma of the colon (Figure 1). A colonoscopy was organised, lesion was further evaluated and found to be partially mobile and demonstrated ulceration on its surface (Figure 2). Histopathology biopsies taken from the lesion was

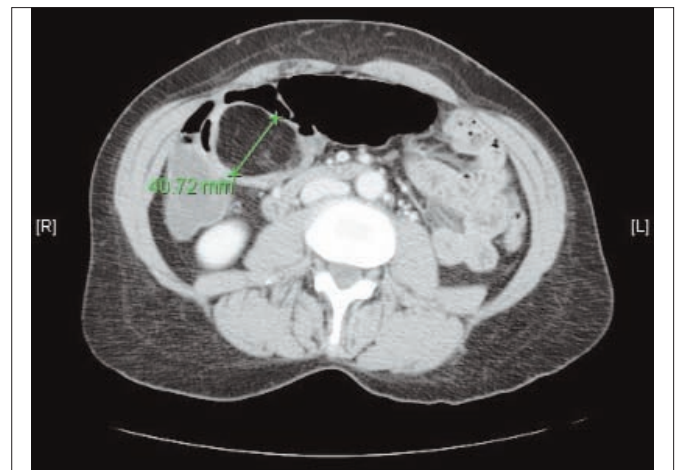


Figure 1: Dimensions of the tumour on CT scan.

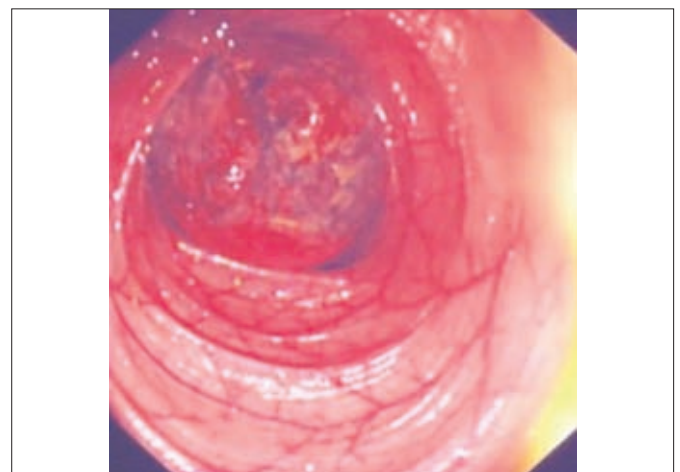


Figure 2: Endoscopic views showing luminal obstruction.

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consistent with lipoma. The case was discussed in multi-disciplinary team (MDT) meeting and subsequently treated with laparoscopic right hemicolectomy. Peri and postoperative recovery was uneventful and patient was discharged home after 4 days. Final histology confirmed the polypoid lipoma with overlying ulceration and active chronic inflammation. Excision was complete and the draining lymph nodes were normal.

### DISCUSSION

The incidence of colonic lipomas is reported between 0.035% and 4.4%, however, only 25% of them produce any symptoms. Most become symptomatic when the size reaches 4 cm or above. Diagnosis of small lipoma is usually incidental during colonoscopy, CT scans or histology specimen after bowel resections. However, sometimes it is difficult to differentiate between the malignant tumours and lipomas because of the ulcerated surface and/or their fixity into the bowel wall.<sup>4</sup> They usually arise from submucosa but 10% extend into muscularis propria and subserosa. Giant lipoma present with symptoms of pain, bowel obstruction, haemorrhage, anaemia and intussusception.<sup>2-4</sup> In this case, it required a colonoscopy and biopsy in addition to CT scan to get the definitive diagnosis. The decision of major colonic resection was carried out after MDT discussion. The final histology confirmed large lipoma with overlying ulceration and active chronic inflammation.

Treatment of colonic lipoma is dependent upon the accuracy of diagnosis, size, site, presenting complaints and complications caused by them.<sup>1,2,5</sup> Autoamputation and expulsion of lipoma has been reported.<sup>3</sup> Endoscopic resection is possible in small lipoma, however, there is a risk of failure and perforation in lesions greater than 2 cm. In contrast, there are reports of lipoma as big as 3.5 cm removed safely using endoscopic techniques. Endoscopic removal of giant colonic lipomas may be technically difficult or even impossible because of their vascular nature, large pedicle, site, fixity and size. In such cases, segmental bowel resection, hemicolectomy, subtotal colectomy using laparoscope or laparotomy is performed.<sup>6</sup> In addition, lipoma is the most common

benign tumour of the colon which causes colonic intussusception.<sup>5</sup> This may require urgent emergency laparotomy and major bowel resections and result in significant morbidity.<sup>5</sup> It is, therefore, important to diagnose such tumours as soon as possible and treat accordingly. In this case, major resection was justified after MDT discussion in view of its presentation and features like large size, ulceration on its surface and fixity.

In view of the latest advancements in laparoscopic techniques, laparoscopic resection of such tumours should become a standard practice. It is, however, important to appreciate the limitations of laparoscopic approach in emergency situations, if patients present with very large tumours, severe bowel distension resulting in difficult and unsafe laparoscopic access. This also implies in patients with co-morbidities and previous abdominal surgeries. Therefore, each case should be carefully assessed, investigated, discussed in MDT and considered for further intervention. Awareness of giant lipoma presenting with intestinal obstruction and treatment options is important.

### REFERENCES

1. Geraci G, Pisello F, Arnone E, Sciuto A, Modica G, Sciume C. Endoscopic resection of a large colonic lipoma: case report and review of literature. *Case Rep Gastroenterol* 2010; **4**:6-11.
2. Aydin HN, Bertin P, Singh K, Arregui M. Safe techniques for endoscopic resection of gastrointestinal lipomas. *Surg Laparosc Endosc Percutan Tech* 2011; **21**:218-22.
3. Jeong HK, Cho SB, Seo TJ, Lee KR, Lee WS, Kim HS, *et al*. Autoamputation of a giant colonic lipoma. *Gut Liver* 2011; **5**: 380-2. Epub 2011 Aug 18.
4. Mnif L, Amouri A, Masmoudi MA, Mezghanni A, Gouiaa N, Boudawara T, *et al*. Giant lipoma of the transverse colon: a case report and review of the literature. *Tunis Med* 2009; **87**:398-402.
5. Krasniqi AS, Hamza AR, Salihi LM, Spahija GS, Bicaj BX, Krasniqi SA, *et al*. Compound double ileoileal and ileocecolic intussusception caused by lipoma of the ileum in an adult patient: a case report. *J Med Case Reports* 2011; **5**:452.
6. Zhang X, Ouyang J, Kim YD. Large ulcerated cecal lipoma mimicking malignancy. *World J Gastrointest Oncol* 2010; **2**: 304-6.

