Colonic lipoma presented with attack of gastroenteritis: Case report

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Figure 1
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Abstract

Lipomas are the most common type of non-epithelial benign tumors of the gastrointestinal tract. This is a report of a case of transverse colonic lipoma which presented with a misleading Gastroenteritis for which upper and lower endoscopies were done for recurrent and persistent symptoms and revealed tumor-like mass in the transverse colon for which transverse colectomy with primary anastomosis was done and histopathology came as the rare colonic lipoma. The gastrointestinal lipoma is a relatively rare disease, and originates from the submucosa of the gastrointestinal tract and occurs the most frequently in the cecum and ascending colon. One of the challenges in the management of colonic lipoma is to establish the diagnosis preoperatively. Three diagnostic tools can bring arguments in favor of the diagnosis: colonoscopy, barium enema and CT

Background

Lipomas of the gastrointestinal tract are benign tumors and are the most common type of non-epithelial (mesenchymal) neoplasm of the gastrointestinal tract [1, 2]. They are rare and most often found incidentally during a colonoscopy, computed tomography (CT) scan, surgery, or autopsy [1, 3]. Lipomas are the third most common benign tumor of the colon, following hyperplastic and adenomatous polyps [2]. Lipomas of the colon were first reported by Bauer in 1757 [4, 5]. Lipomas are most often located in the ascending colon (45%), although tumors may occur in the sigmoid colon (30.3%), descending colon (15.2%), and transverse colon (9.1%) [1, 2, 6]. The most common age is the fifth or the sixth decade of life. Female predominance has been reported, but other authors have found no sex predilection [1, 2]. The incidence is estimated about 0.035-4.9% because they are rarely symptomatic unless they reach a certain size. They are mostly solitary, but may be multiple in 6-20% of cases [1, 2, 4]. Most colonic lipomas are asymptomatic and need no treatment [4, 5]. However, about 30% reach 2 cm or larger in size and may produce symptoms. The symptoms occur in about one-fourth of patients with lipomas. Abdominal pain and discomfort change in bowel habits, diarrhea, and rectal bleeding or even melena can be seen [6-8]. They may have serious consequences like life-threatening hemorrhage, intussusception, and intestinal obstruction. Even spontaneous expulsion has been reported [1, 6-8]. In addition, lesions larger than 4 cm may lead to perforation, or gastrointestinal bleeding due to ulceration of the lesion. Extremely uncommon, transformation to liposarcoma has been documented [1, 3, 9].

When diameter exceeds 2 cm, symptoms are likely to appear. Smaller lesions are found incidentally with increased use of colonoscopy and they can be managed endoscopically [1, 5]. Preoperative diagnosis is important for planning; however, due to variable presentation and appearance, discrimination from malignant lesions can be difficult. There are different modalities for diagnosis of colonic lipomas [2, 7, 8, 10]. They are seen as an ovoid, well demarcated radiolucent mass in barium enema series. "Squeeze sign" is the change of a lipoma into a fusiform appearance with the colonic peristalsis, but it is not totally reliable because if the lesion is located in the right colon or ulcerated it is hard to differentiate from colonic malignancy [7, 8]. Colonic lipomas are usually seen as a submucosal mass covered by normal colonic mucosa at colonoscopy. Elevation of mucosa by the biopsy forceps ("tent sign"), indentation by pressing on it ("cushion sign"), or extrusion of fat after biopsy ("naked fat sign") can also be seen. Sometimes necrotic mucosa, ulceration, and relatively hard texture of the lesion make it difficult to differentiate from a malignant lesion. When the lesion is actively bleeding, endoscopic biopsy may not be safe and reliable. Computed tomography has been reported to be the most useful tool for detection of these lesions. Generally, they are seen as spherical or ovoid masses with absorption densities of -40 to -120 Hounsfield units, typical of fat. CT appearance may be atypical if fat necrosis or infarction is present. For large colonic lipomas and acutely ill patients, CT and MRI may be more useful in showing fatty composition of the tumor [1, 7-9]. Despite the diagnostic tools, differentiation from malignant processes is the main challenge before surgical resection. A firm diagnosis of colonic lipoma can be established fundamentally based on the histopathological examination [3, 9, 11, 12].
Ninety percent of colonic lipomas are localized to the submucosa; colonic lipomas are rarely found in other layers of the bowel wall [5, 9, 13, 14]. Furthermore, the submucosal location of these tumors has led to several techniques for endoscopic removal, including endoloop excision, nylon loop-assisted removal, endoclipping, and sectioning of the overlying mucosa via segmental cuts. However, endoscopic resection of large CL is controversial, because of prior reports of a high rate of perforation. It is postulated that lipomatous tissue contains low water content and therefore conducts electrosurgical current less efficiently. Thus, increasing the power to assist the endoscopic resection may lead to increased heat production and damage to the adjacent bowel wall with subsequent perforation [1, 7, 12, 14]. One of the most common and feared complications of endoscopic removal is colonic perforation, although its true incidence is likely underestimated due to the rarity of lipomas. The clinical diagnosis of a lipoma can be very difficult [7, 12, 14]. In fact, several cases of lipomas with overlying villous adenomas or other presentations mimicking carcinomas have been reported in the literature [7, 12, 15]. In most cases; segmental surgical resection is the most appropriate treatment, as it ensures proper collection of lymph nodes for appropriate staging of presumed colonic carcinoma. According to Jiang and colleagues, surgical intervention is warranted when the lipoma is more than 4 cm in size; there is an unclear preoperative diagnosis; the lipoma has associated morbidity (intussusception) and the patient is symptomatic; there is involvement of the muscular or serosal layer; or the lesion cannot be radically resected endoscopically [7, 12, 14].

This is a case of transverse colonic lipoma which was presented with a misleading Gastroenteritis for which upper and lower endoscopies were done for recurrent and persistent symptoms and revealed tumor like mass in the transverse colon for which transverse colectomy with primary anastomosis was done and histopathology came as the rare colonic lipoma.

Case report

A 38 years old male with no co-morbidities, with history of appendectomy few years back, came to Emergency room with 5 days history of left sided abdominal pain, which was associated with vomiting and diarrhea. Flagyl and antispasmodic were prescribed and he was sent home. Next day presented again with persistent abdominal pain which became diffuse and associated with distension, Loose motion 7-9 times, Blood in stools, Abdomen lax was lax on examination. Plain abdominal radiograph was unremarkable (Figure 1).

Pelviabdominal U/S showed Fatty liver. The patient was admitted under Internal Medicine as Gastroenteritis. Stool analysis showed Entamoeba histolytica cysts with RBCs and pus cells. The patient condition improved on flagyl and ciprofloxacin and was discharged after 7 days. During follow up in the outpatient clinic he was still complaining of epigastric pain. Upper Gastrointestinal endoscopy was done revealed mild non-erosive antral gastritis (Figure 2).

As the patient was still complaining of abdominal pain in the epigastric area a suspicion of transverse colonic mass was confirmed by colonoscopy which showed 4-5 cm polypoid mass in mid-transverse colon with ulcerated surface and long stalk with significant luminal narrowing and was biopsied (Figure 3). Colonoscopic biopsy revealed ulceration, granulation tissue with spindle cell formation and epithelial cells insufficient for diagnosis.

Pelviabdominal Computed tomography showed large polyp at the distal transverse colon surrounded by mucosal thickening and fat stranding which could represent malignant features, Intussusception is a differential diagnosis (Figure 4).

Transverse coectomy with primary anastomosis was done, and final histopathology came as submucosal lipoma with mucosal ulceration, focal areas of hemorrhage and hyperplasic changes. The patient had an uneventful postoperative course and was discharged home on the fifth postoperative day.

Discussion

The incidence of colonic lipoma ranges between 0.035 and 4.9%. Most of bowel lipomas are located in the colon, the most common site. There is a feminine predominance, and the age of discovery is generally between 50 and 65 years. The symptomatology is not specific. The majority of colonic lipomas are asymptomatic and do not require treatment, however, a small number may cause symptoms when the lesion is large, particularly those with a diameter >2 cm. They can result in persistent or intermittent abdominal pain, bloating, changes in bowel habits, gastrointestinal bleeding, bowel obstruction, or intussusception. One of the remaining challenges in the management of colonic lipoma is to establish the diagnosis preoperatively. They are often found incidentally during colonoscopy or radiologic imaging. Three diagnostic tools can bring arguments in favor of the diagnosis: colonoscopy allows mostly visualizing the
lipomatous lesion characterized by a rise of the mucous membrane, softness of the mass under the biopsy forceps and finally the visualization of yellow fat on biopsy. Endoscopic or surgical removal is indicated for symptomatic colonic lipomas or when malignancy is suspected or known. In this case, the pre-operative biopsy during colonoscopy revealed numerous ulcerative lesions with local epithelial regeneration, without malignant tumor cells. The patient underwent segmental resection of the transverse colon.

We found that this is only the eighth report of a transverse colonic lipoma published in the literature. The size of colonic lipomas ranges between 2 mm and 30 cm and may mimic colonic malignancies. The present case revealed that large colonic lipomas and malignant tumors may be difficult to differentiate prior to resection if only endoscopic observations are used. Due to the nonspecific clinical presentations and endoscopic appearance, including the multiple areas of erosion and ulceration that were identified on the mass surface, the two may be indistinguishable. However, for colonic lipomas of a large size and in acutely ill patients, CT is the preferred diagnostic method, as the imaging characteristics of the tumors are fairly typical for adipose tissue.

In this case, an intraoperative frozen section may provide an accurate diagnosis to guide surgery. In the present case, the preoperative biopsy during colonoscopy revealed ulceration, granulation tissue with spindle cell formation and epithelial cells insufficient for diagnosis. The patient underwent transverse colectomy with primary anastomosis. Final histopathology revealed submucosal lipoma with mucosal ulceration, focal areas of hemorrhage and hyperplastic changes.

Conclusions

Colonic lipoma is a relatively rare benign tumor, which as a clinical entity may be easily misdiagnosed as a malignant tumor. The clinical awareness of colonic lipomas must be increased. The clinical presentation of colonic lipomas may be anywhere in the spectrum between asymptomatic lesions and life-threatening complications. Laparoscopic resection can be the first choice in patients with unclear preoperative diagnosis, complicated cases like intussusception, lipomas not suitable for endoscopic removal, whenever endoscopic removal cannot be performed safely with negative margins, and lipomas located in the muscular or serosal layer. Laparoscopic resection is a good alternative to open conventional surgery with all the known advantages of minimally invasive procedures.

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