

Lipoma of the Descending Colon Causing Acute Large-Bowel Intussusception

S Sarker

Citation

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Abstract

We present an unusual case of colonic lipoma causing acute large-bowel obstruction. It is unusual as the patient did not have preceding gastro-intestinal symptoms of intussusception and presented on the first occasion with acute large obstruction. This is surprising as the lipoma measured 10cm and is the largest colonic lipoma reported to date. Although acute intussusception and acute large-bowel obstruction due to a colonic lipoma is rare, it still needs to be considered in the initial differential diagnosis in large bowel obstruction.

CASE REPORT

A 55-year-old man presented acutely with large-bowel obstruction to the Emergency Department at our hospital. He had no preceding gastro-intestinal symptoms prior to his admission. Clinically, he had a grossly distended abdomen and right iliac fossa peritonism. He was appropriately resuscitated. A CT scan of the abdomen (Figure 1) showed an intussuscepting lesion in the descending colon just distal to the splenic flexure causing complete large-bowel obstruction and dilating the caecum to more than 10cm. As a result of these findings and the suspicion of a malignant colonic neoplasia, he had an emergency laparotomy, extended right hemi-colectomy and primary colonic anastomosis. Post-operatively, he had an unremarkable recovery and was discharged 5 days later. Histology of the colectomy specimen showed the lesion to be a colonic lipoma of 10cm causing intussusception of the descending colon. Lipomas of the colon are common and often seen on colonoscopy. However, they rarely cause acute large-bowel obstruction as in this case.

Figure 1

Figure 1 - Coronal Abdominal CT of Intussuscepting Lipoma



DISCUSSION

Intussusception occurs when a proximal segment of the bowel telescopes into an adjacent distal segment⁷. The typical symptoms found in adult patients with intussusceptions are often chronic; such as abdominal pain, fever, nausea, vomiting, melaena, weight loss, and constipation. Physical examination may demonstrate diffuse or localized abdominal tenderness, while an abdominal mass is detected in a minority of cases^{8,9}. In our case, these symptoms and signs did not occur, with a first presentation of acute large-bowel obstruction. The use of computed tomography in the evaluation of patients with uncharacteristic abdominal pain may allow the condition to

be more reliably diagnosed. However, in our case a colonic malignancy could not be ruled out and therefore the patient had an emergency laparotomy. Resection or reduction of the colon involved is still controversial. However, many speculate against reduction before resection, especially when taking into account cases where the bowel is nonviable or when malignancy is suspected.

Lipoma of the colon is an uncommon tumor of the gastrointestinal tract. In general, colonic lipomas do not cause symptoms and, therefore, are usually detected incidentally during colonoscopy, surgery and autopsy. However, a minority of lipomas can cause symptoms when the lesion is large, especially for those with a diameter greater than 2cm^{1,3-5}. With the widespread application of colonoscopy, small lesions are found incidentally, and their diagnosis and treatment are mainly dependent on endoscopy¹⁻³. Large colonic lipomas are often mistaken for more serious pathology, as a result of their rarity and variable presentation. Therefore, more attention should be paid to how to increase the rate of preoperative diagnosis. Clinical features are still important, especially for those large lesions.

Many therapeutic interventions have been tried for the treatment of colonic lipoma, which have varied from hemicolectomy to segmental resection and local excision, according to the correct preoperative diagnosis and intraoperative findings. With the advancement of colonoscopy, endoscopic cautery snare resection of colonic lipomas has become popular and has been proven to be a safe therapeutic method, especially for small lesions^{1,3,4,10,11,12}. This is unlikely to be of value in large lipomas as in our case, and resection would be recommended in large colonic lipomas. The removal of colonic lipoma with the assistance of laparoscopy has also been reported¹³, but this would be contraindicated in a patient with acute bowel obstruction.

Our case is unusual as the patient did not have preceding gastro-intestinal symptoms of intussusception and presented with acute large-bowel obstruction. This is surprising as the lipoma measured 10cm and is the largest colonic lipoma reported to date. Although acute intussusception and acute large-bowel obstruction due to a colonic lipoma is rare, it still needs to be considered in the initial differential diagnosis.

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Author Information

Sudip K. Sarker, FRCS (Gen Surg) PhD

Lecturer in Surgery, Academic Surgery, University College