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LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
Intestinal obstruction due to a giant lipoma of the Ascending colon: A case report

Çıkan kolonda bağırsak obstruksiyonuna neden olan dev lipomlu hasta

To the Editor

A 51-year-old male patient was admitted to hospital with emergency abdominal pain associated with bowel obstruction. He had no past history of any cancer and no family history of colorectal cancer. Physical examination revealed a tender mass located in the right hypochondrium. Results of laboratory investigations were as follows: Hb: 12.2 g/dl, WBC: 12,400/mm^3. Serum electrolytes, amylase and other blood biochemistry results were within normal limits. Supine plain X-ray of the abdomen demonstrated multiple air-fluid levels, and markedly dilated large bowel loops. An abdominal ultrasonography demonstrated a solid mass 7x10 cm in size in the right hipochondrium. At surgery a large mass and mucosal intussusception at the hepatic flexura of the ascending colon were identified, and right hemicolectomy was performed. The hemicolectomy specimen measured 46x6-8 cm in size. At dissection, a soft polypoid mass 8 cm in diameter which occupied almost the entire lumen of the colon was seen (Figure 1). The cut surface of the lesion was yellowish-brown in color. Microscopically it consisted of mature adipose tissue mixed with various amounts of fibrous tissue with some areas of necrosis and hemorrhage. The microscopic analysis confirmed the diagnosis of lipoma of the submucosal layer of the colon (Figure 2).

Gastrointestinal lipomas are rare, benign, usually single and slow-growing tumors (1). Although lipomas of the colon are second only to adenomatous polyps in frequency of benign lesions of the large bowel, they occur relatively rarely and can continue to present difficulties in the preoperative differentiation between malignant and benign colonic neoplasms (2, 3). Colonic lipomas are most frequent in the right colon and tend to occur on or near the ileocecal valve, followed by rectum, sigmoid colon and descending colon (3, 4). Lipomas are usually asymptomatic and detected incidentally (5, 6). We report a man with a colonic lipoma who presented as an acute abdominal emergency with nearly total colonic obstruction and severe pain associated with intussusception. The purpose of the present paper is to stress diagnostic and therapeutic problems related to this condition.

Lipomas are rare but well-recognized tumors of the gastrointestinal tractus. The lesions occur with maximum frequency in the fifth to sixth decade of life and mostly in women (4, 5). They are more commonly seen in the large intestine with a

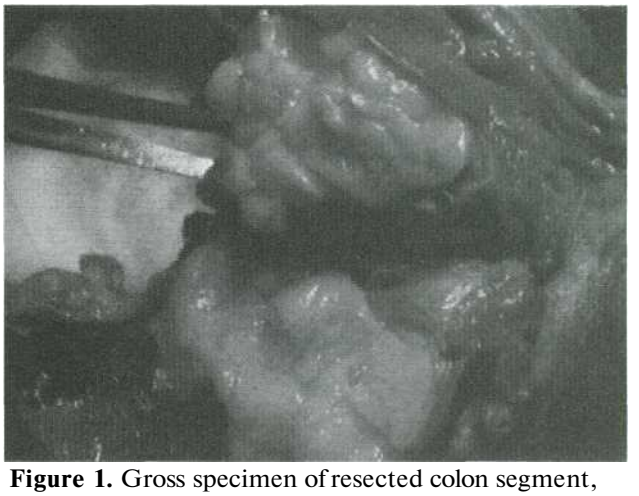

Figure 1. Gross specimen of resected colon segment, which includes the lipomatous lesion

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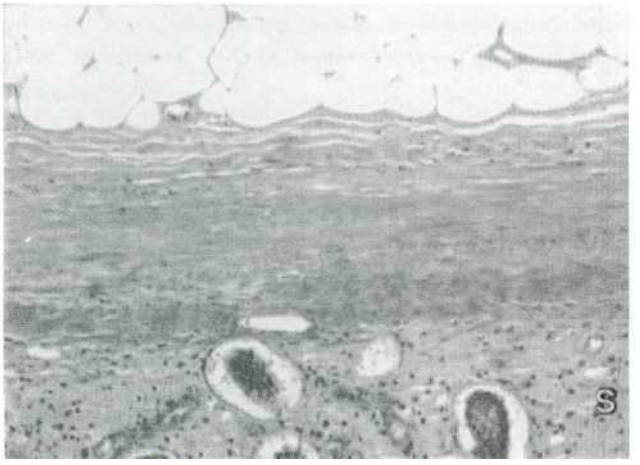

Figure 2. Histological feature of resected specimen showing lipoma (HEx100)

frequency of from 0.3% to 5.8% in the whole population depending on clinical or autopsy series (6). Almost all gastrointestinal lipomas are submucosal or subserosal and most are asymptomatic (7, 8). Their clinical symptoms are directly related to their size (5).

With the increase in the number of endoscopic procedures being performed, these tumors are often detected incidentally at colonoscopy (8, 9). Colonoscopy is the preferred modality for small lipomas, whereas CT and MR imaging are more useful in detecting fatty masses and assessing the location of lesions. Barium enema study may contribute to the preoperative planning in selected cases (10, 11). Colonoscopic removal of submucosal lipomas is recommended while surgical treatment is necessary in the presence of intussusception or subserosal lipomas (12). Although endoscopic removal of pedunculated submucosal lipomas of the colon has been considered safe and effective, caution should be exercised in endoscopic removal of large lipomas (more than 3 cm) in terms of colonic perforation, even when a pedicle is present (13, 14).

Our case presented as an emergency with abdominal pain associated with bowel obstruction. He had a three-month history of intermittent right-sided abdominal pain and constipation. At laparotomy there was a mass in the ascending colon, next to the hepatic flexura, and right hemicolectomy was performed. In expert hands, pedunculated and sessile lesions can be removed endoscopically but, as in our case, emergency operations may be carried out for complications. In conclusion, awareness of the possibility of colonic lipomas is important for clinicians in terms of evaluation of therapeutic regimen, particulary in cases of emergency.

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