sal tumor, measuring 15x15 mm in diameter (Figure 1b). The tumor was surgically resected and photomicrographic findings included a tumor composed of mature adipose tissue in the submucosa, which was consistent with a diagnosis of lipoma.

Lipomas constitute about 10% of the gastrointestinal benign tumors (1), and there are limited scattered cases in the literature of intestinal lipomas presented with bleeding (2-3), and bleeding and intussusception (4-6). Symptoms due to invagination in adults tend to be chronic or intermittent and include pain, constipation, weight loss, or a palpable abdominal mass at physical examination. Like in our case, the CT findings in intussusception are usually pathognomonic, including a target-like mass, oral contrast material trapped between the opposing walls of the intussusceptum and intussuscipiens, and a soft-tissue mass secondary to the intussusception, possibly with the accompanying lead point. If blood supply is compromised, bowel-wall thickening, as seen in this case, or intramural air may be seen (7).

Interestingly, our case presented with both abdominal colicky pain due to intermittent intussusception and gastrointestinal bleeding, which prompted us to search for its source. We report this patient to alert physicians to investigate the small intestine in case of unexplained, chronic abdominal pain. Overt or occult bleeding sources can easily be detected and treated by a relatively new, safe technique, namely DBE.

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An atypical initial presentation of Crohn's disease

Crohn hastalığında atipik klinik başlangıcı olan bir olgu

To the Editor

Osteoporosis is prevalent in Crohn's disease (CD), but fracture is an uncommon initial presentation (1-3). A 29-year-old male was admitted with recent onset right ankle pain and hip strain. He had a history of femur fracture with minor trauma the year before. Physical examination revealed right lower quadrant tenderness. Abnormal laboratory parameters were: hemoglobin: 10.0 g/dl, hematoc-

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rit 30%, mean corpuscular volume: 115 fL, white blood cell count 12,000/mm^3, sedimentation rate: 40 mm/hr, total serum calcium: 5.0 mg/dl, ionized calcium: 0.8 mmol/L, phosphorus: 2.2 mg/dl, magnesium: 1.3 mg/dl, alkaline phosphatase: 506 U/L, vitamin B12: 100 ng/L, parathyroid hormone: 651 pg/ml, and vitamin D: 10 nmol/L. The X-ray showed fracture at the right distal fibula (Figure 1). Abdominal ultrasonography showed thickened terminal ileum wall and fistula tract with fluid collection at right lower quadrant. Colonoscopy revealed cobblestone appearance plus strictures at the ileum with patchy, large, deep and linear ulcers throughout the colon and normal rectum. The biopsy from the terminal ileum revealed epithelioid granuloma, ulceration, and lymphocytic and plasmacytic inflammation of the lamina propria. The findings were consistent with CD complicated with osteomalacia. Ileum resection and ileocolectomy were performed, and the patient was discharged in the postoperative period with a treatment of azathioprine, mesalazine, calcium plus vitamin D and vitamin B12. He was well during the follow-up period.

Osteoporosis may be multifactorial in CD. Glucocorticoid therapy, hypogonadism, vitamin D deficiency and low body weight are all contributing factors. Calcium deficiency may occur as a result of inadequate dietary intake or intestinal malabsorption. Secondary hyperparathyroidism due to a lesser degree of vitamin D deficiency results in increased bone turnover, causing predominantly cortical bone loss (4). Inflamed intestinal mucosa cytokines, interleukin-1, interleukin-6 and tumor necrosis factor alpha (5), by increasing the generation and activity of osteoclasts, may be another possible mechanism. The fracture in our patient may indicate that the disease was present for a long period before the diagnosis. A delay in making a definite diagnosis and thus in management was probably complicated by the osteoporotic fracture.

In conclusion, osteoporosis may be the first presentation, and gastrointestinal symptoms may not dominate even in complicated CD. When the patient is diagnosed as CD, the evaluation for osteoporosis should be started promptly and when the levels are low, treatment with calcium, magnesium and vitamin D should be implemented.

Figure 1. Arrow shows a fracture at the right distal fibula.

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