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LETTERS TO THE EDITOR
EDİTÖRE MEKTUPLAR
Jejunal lipoma causing intussusception and gastrointestinal bleeding

Kanama ve intussepsiyon nedeni olarak jejunal lipom

To the Editor

Gastrointestinal lipomas are rare benign tumors commonly found in the colon near the ileocecal valve (1). They are slowly growing, submucosal tumors, which frequently may cause intussusception but rarely bleeding. Because the small intestine is relatively inaccessible to routine endoscopy, diagnosis of small intestinal neoplasms is often delayed. However, a relatively new imaging technique, double-balloon enteroscopy (DBE), may permit earlier, nonoperative diagnosis. Here, we report a patient who presented with unexplained abdominal colicky pain and previous massive gastrointestinal hemorrhage due to an ulcerated jejunal lipoma, which was first recognized by computerized tomography (CT) and subsequently verified by DBE.

A 61-year-old woman was admitted to our hospital due to abdominal colicky pain for two years. She denied any loss of appetite and had no weight loss. In her medical history, she had a massive gastrointestinal bleeding (hematemesis and hematochezia) six months ago, for which she was transfused repeatedly. However, at that point in time, neither the upper nor lower gastrointestinal endoscopy, performed in another hospital. Despite antacid therapy there was no pain relief. On physical examination, she was pale and had mild abdominal tenderness. Laboratory results were normal except for hypochromia, microcytic anemia (Hct 18.3%), and low ferritin levels [(5 ng/ml (10-350 ng/ml)]. Searching for the etiology of abdominal pain and iron deficiency anemia, a gastroscopy and colonoscopy were performed for the second time, but no specific findings were detected. A subsequent CT showed thickening of the jejunum, and "target sign" typical for invagination, and homogeneous fat density mass image almost filling the lumen (Figure 1a). A subsequent peroral DBE disclosed an ulcerated, yellowish, sessile submuco-

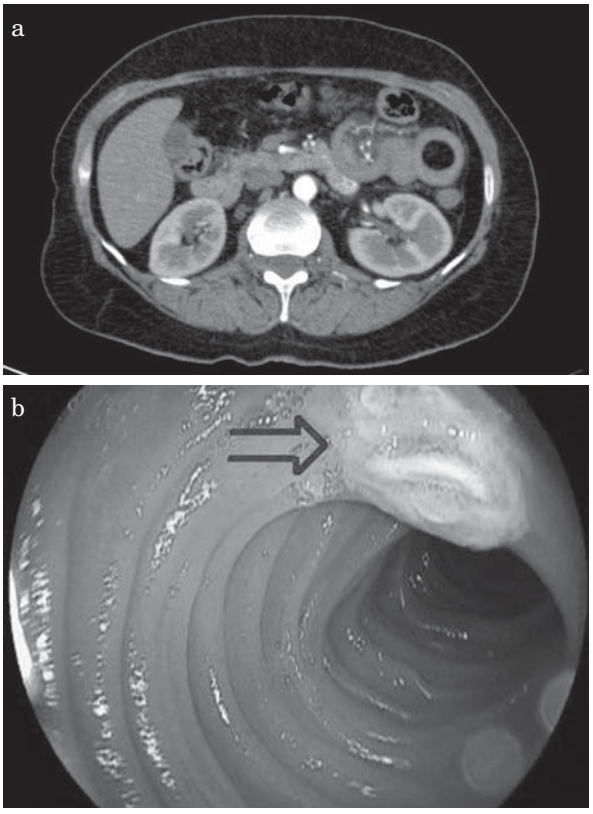

Figure 1a. Axial CT postcontrast image showing fat density round lesion as the lead point of jejunojejunal intussusception in the left upper quadrant. **1b.** Ulcerated jejunal lipoma image taken during DBE.

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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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