Turk J Gastroenterol *2017; 28: 65-6*

Lipoma-induced colonic intussusception in mobile cecum syndrome

To the Editor,

A 49-year-old man presented with intermittent upper abdominal pain at a local clinic. However, no abnormality was found on physical examination and abdominal sonography. A week later, the pain had aggravated and an upper abdominal mass was palpable. Repeated abdominal sonography revealed a 3.6-cm sized mass in the upper abdomen. On admission, the patient's vital signs were within normal limits. His white blood cell count was 10,770 cells/uL (neutrophil 79.7%), but liver function test was normal, and amylase, lipase, and electrolyte levels were within the normal range. After admission, he exhibited hematochezia. Computed tomography (CT) of the abdomen and pelvis revealed a colonic intraluminal fatty mass with associated intussusception of the mesentery at the level of the distal transverse colon (Figure 1a, arrow). However, a previous abdominopelvic CT performed several months ago during a routine health check-up at our hospital revealed a colonic lipoma in the ascending colon (Figure 1b, arrow). Laparotomy revealed that the cecum had moved across the abdomen and was invaginated into the distal transverse colon, resulting in colocolic intussusception. After manual reduction of the intussusception, a globe-shaped mass was palpable in the cecum, and a right hemicolectomy with ileocolic anastomosis was performed. Pathology of the resected cecum revealed a 5.5×4.5×4.5-cm semi-pedunculated submucosal tumor with a yellowish fatty tissue. The surface was exudative and necrotic (Figure 2). A diagnosis of lipoma-induced colonic intussusception in mobile cecum syndrome was confirmed. The patient had an uneventful postoperative recovery and remains well.

Mobile cecum is characterized by an abnormal mobility of the cecum and ascending colon due to the failure of the cecum and right colon to fuse to the posterior parietal peritoneal wall (1). Although abnormal mobility of the cecum and ascending colon is present in 10%–20% of the population, it rarely develops as a symptomatic

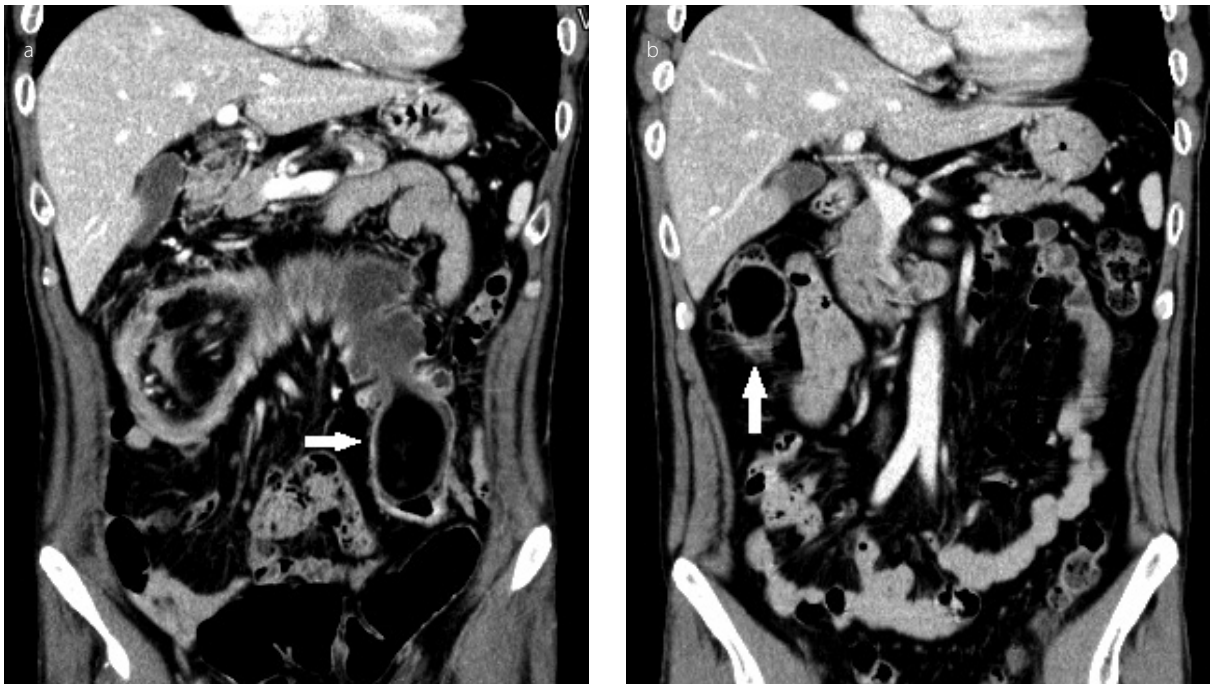

Figure 1. a, b. (a) Abdominopelvic computed tomography (CT) at admission showed a colonic intraluminal fatty mass with associated intussusception of the mesentery at the level of the distal transverse colon (arrow). (b) Abdominopelvic CT performed 2 years ago showed a colonic lipoma in the ascending colon (arrow)

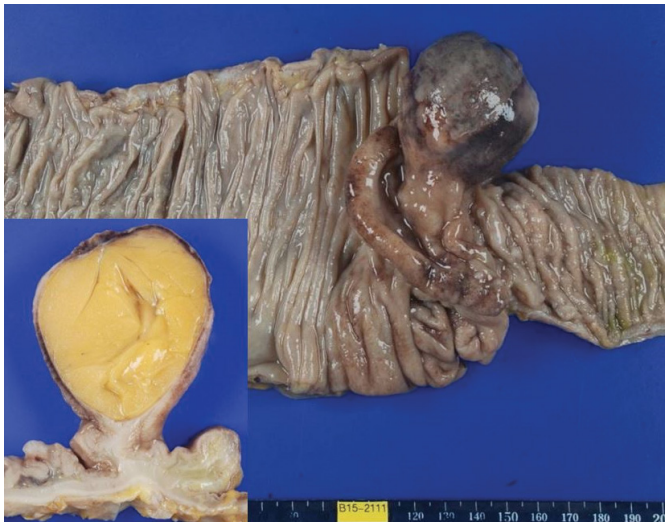

Figure 2. Pathology of the resected cecum showed a 5.5×4.5×4.5-cm semi-pedunculated submucosal tumor with a yellowish fatty tissue. The surface was exudative and necrotic

disease (2,3). Common symptoms are colicky abdominal pain, abdominal distension, and chronic periumbilical or right lower quadrant pain, which are usually relieved by passing flatus or stool (1). It can also manifest as a cecal volvulus. If a patient with mobile cecum syndrome has recurrent symptoms or volvulus, the treatment of choice is cecopexy using lateral peritoneal flap (1,3). Colonic lipomas are relatively uncommon and frequently asymptomatic; however, lipoma larger than 2 cm in size are more likely to cause complications. To the best of our knowledge, colonic intussusception induced by cecal lipoma in a patient with mobile cecum, as in our case, has not yet been reported. Preoperative diagnosis of mobile cecum was important in this patient because it could affect the surgical plan. Therefore, if CT shows that the cecum or cecal lipoma has intussuscepted into the far distal colon, mobile cecum syndrome should be considered before emergency laparotomy.

Ethics Committee Approval: N/A.

Informed Consent: Written informed consent was obtained from the patient who participated in this study.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept – J.T.O., Y.S.K.; Data Collection and/or Processing – J.T.O., Y.S.W.; Analysis and/or Interpretation – S.Y.L., J.J.; Literature Search – S.Y.L., J.J., Y.S.W.; Writing – S.Y.L., Y.S.K.; Critical Reviews – Y.S.K., J.T.O.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: This work was supported by Wonkwang University 2015 (YSK)

Seok Youn Lee[1], Yong Sung Kim[2], Yong Sik Woo[2], Jaehoon Jahng[1], Jung Taek Oh[3]

[1]Department of Surgery and Wonkwang University Sanbon Hospital, Gunpo, Republic of Korea

[2]Department of Internal Medicine, Wonkwang University Sanbon Hospital, Gunpo, Republic of Korea

[3]Department of Surgery, Kunsan Medical Center, Kunsan, Republic of Korea

REFERENCES

1. Rogers RL, Harford FJ. Mobile cecum syndrome. Dis Colon Rectum 1984; 27: 399-402. [CrossRef]
2. Garude K, Rao S. Mobile cecum: an incidental finding. Indian J Surg 2013; 75: 265-7. [CrossRef]
3. Tsushimi T, Kurazumi H, Takemoto Y, et al. Laparoscopic cecopexy for mobile cecum syndrome manifesting as cecal volvulus: report of a case. Surg Today 2008; 38: 359-62.[CrossRef]

Address for Correspondence: Yong Sung Kim
E-mail: wms89@hanmail.net
Received: November 10, 2016 **Accepted:** November 13, 2016

Available online at www.turkjgastroenterol.org • DOI: 10.5152/tjg.2016.0643