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Case Report

CAECAL LIPOMA CAUSING CAECO-COLONIC INTUSSUSCEPTION WITHOUT OBSTRUCTION: A RARE CASE REPORT

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ABSTRACT

Colonic lipomas are uncommon nonepithelial neoplasms that are typically sessile, asymptomatic and incidentally found during endoscopy, surgery, or autopsy. We present a very rare case of a 43-year-old male patient with symptomatic caecal lipoma causing intermittent abdominal pain with intussusception. Preoperative diagnosis was established and the patient underwent exploratory laparotomy. Intraoperatively, intussusception of the caecum into the ascending colon was found and right hemicolectomy was performed. Macroscopic assessment of the resected specimen showed the presence of a large caecal tumor with features of lipoma, causing intussusception. Histopathological examination confirmed the diagnosis of caecal lipoma.

INTRODUCTION

A 43 year old male patient presented to the OPD with complaints of intermittent right lower abdominal pain since 1 month. There were no complaints of abdominal distention, vomiting or constipation. No history of rectal bleeding or melena. No history of weight loss. On examination patient was averagely built, no anemia, no dehydration. Abdomen was soft with mild tenderness in right lower quadrant. On auscultation normal bowel sounds were heard. Laboratory work up including complete blood count, liver function tests, renal function tests and coagulation profile were within normal limits. Contrast enhanced CT scan of abdomen and pelvis revealed right ileo- colic intussusception with entangled mesentery. The lead point being colonic lipoma measuring approximately6*6cm in size. No bowel obstruction. (fig.1)

Patient was prepared and taken for elective surgery. Intraoperatively inversion of the caecum into the ascending colon with pulled in mesentery was seen. (Fig.2) Ileo-colic junction was patent. There were no signs of small bowel obstruction. Attempts to mechanically reduce the intussusception failed and the lead point bowel wall appeared gangrenous. Hence, a right hemicolectomy was performed. The resected specimen revealed a large homogeneous tumor arising from the Caecal wall with gangrene tip with patent IC junction. (Fig.3).

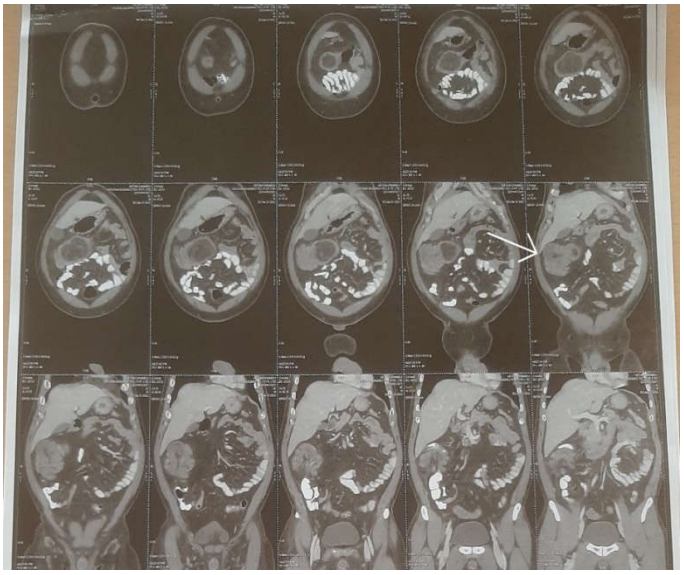

Fig 1 CT scan

Histopathological examination of the resected specimen confirmed the diagnosis of submucosal Caecal Lipoma. The post-operative course of the patient was uneventful and he was discharged on the 8th postop day.

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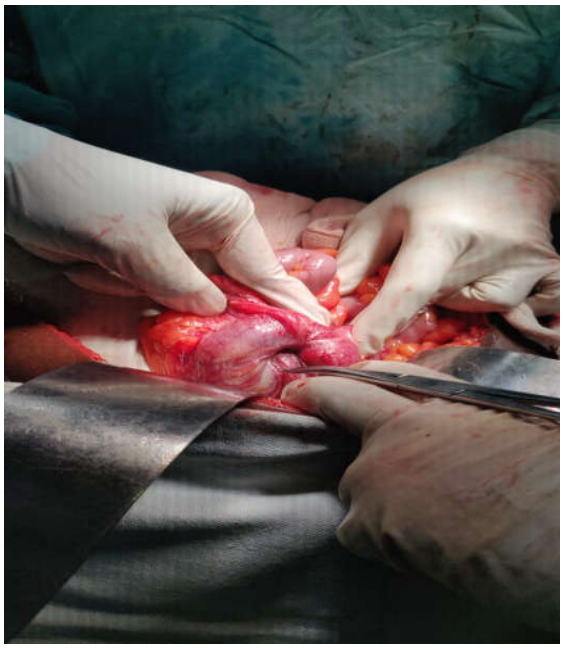

Fig 2 Intra Op – inversion of caecum with pulled in mesentery

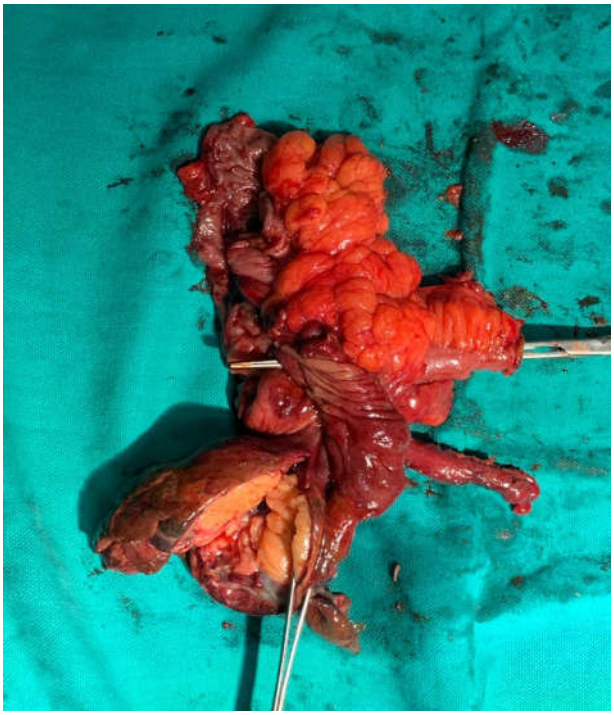

Fig 3 Resected Specimen

DISCUSSION

Lipomas of the gastrointestinal tract were first described by Bauer in 1757 [1]. Colonic lipomas are relatively uncommon tumors of mesenchymal origin, composed of well-differentiated adipose tissue supported by fibrous tissue, that rarely cause symptoms and are usually detected incidentally[2-4]. They arise from the submucosa, but occasionally extend into the muscularis propria; up to 10% are subserosal [5]. The incidence of lipomas relative to all polypoid lesions of the large intestine is reported to range from 0.035% to 4.4% [2, 3]. However, they represent the third most common benign tumors after hyperplastic and adenomatous polyps [6]. They are usually solitary, but multiple lesions are reported in 10% to 25% of cases [2, 4].Colonic lipomas are mainly found on the right-side of the colon and caecum [7] and are mainly asymptomatic. Occasionally they may present with abdominal pain, rectal bleeding, intermittent diarrhea, obstruction, or rarely with intussusception as in our case [8].Recently, Paškauskas *et al*. reviewing the English-language publications of colonic lipomas causing intussusception found less than 50 cases [9]; of these, only in four the intussuscepted segment was caecum-ascending colon.

Imaging modalities can contribute to the preoperative diagnosis of colonic lipomas. Barium enema usually reveals a filling defect; however this finding is nonspecific of colonic lipoma or any other type of colonic neoplasm. Abdominal CT represents a valuable noninvasive imaging modality for the diagnosis of colonic lipomas [10] as these tumors have characteristic fatty densitometric values (−40 till −120 Hounsfield units) [11]. However, occasionally colon lipomas might have atypical CT presentation, especially when intussuscepted, due to varying degrees of infarction/fat necrosis. Colonoscopy is the suggested procedure when a diagnosis of colonic cancer is suspected [10].

Treatment options of colonic lipomas are various and include endoscopic and surgical procedures. Endoscopic resection is generally recommended for lipomas with a diameter smaller than 2 cm or pedunculated lipomas with thin stalk [12], as in these cases the risk of complications following endoscopic resection is considerably low. However according to Katsinelos *et al*., if a lipoma is sessile or broadly-based, even if its diameter is less than 2 cm, endoscopic removal is risky because the adipose tissue is an inefficient conductor for electric current and may result in a significantly high rate of complications like perforation or hemorrhage [13]. The majority of authors recommend surgery as the standard method of treatment for every colonic lipoma greater than 2 cm in size [9, 12]. Surgical treatment includes colotomy with local excision, limited colon resection, segmental resection, hemicolectomy, or subtotal colectomy. The choice of any of the above-mentioned surgical interventions mainly depends on the lipoma size, location, and the presence or absence of definite preoperative diagnosis or disease complications [12]. During last few years some selected cases of successful laparoscopic resection under colonoscopic guidance, of symptomatic colonic lipomas, have been reported [14, 15].

In this case report, the option of an elective surgical approach by performing a right hemicolectomy was planned since preoperative diagnosis was established and the intussuscepted segment was irreducible.

Consent

Written informed consent was obtained from our patient for publication of this case report and any accompanying images.

Conflict of Interests

The authors declare that they have no conflict of interests.

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