

## Colonic invaginated lipoma

### *Lipoma colônico invaginado*

João Paulo Luvizotto Alcântara de Pádua<sup>1</sup>, Augusto Castelli von Atzingen<sup>2</sup>, Rogério Mendes Grande<sup>3</sup>, Henrique de Brito Pires Cabeças<sup>4</sup>

#### ABSTRACT

The colonic lipoma, although rare, is the second most frequent benign tumor in the large intestine. Most of the times is small and asymptomatic. When symptomatic, are larger than 2 cm, and present with abdominal pain, blood in stool and change of bowel habits. The objective of this work is to report a case of lipoma, colonic, in addition to speak about the symptoms and treatment.

**Keywords:** Lipoma; Colonic Neoplasms; Colon.

#### RESUMO

O lipoma colônico, apesar de raro, é o segundo tumor benigno mais frequente do intestino grosso. Na maioria das vezes é pequeno e assintomático. Quando sintomáticos, são maiores que 2 cm, e apresentam-se com dor abdominal, sangue nas fezes e alteração dos hábitos intestinais. O objetivo deste trabalho é relatar um caso de lipoma colônico, além de dissertar a respeito da sintomatologia, diagnóstico e formas de apresentação e tratamento do mesmo.

**Palavras-chave:** Lipoma; Neoplasias do Colo; Colo.

<sup>1</sup> Graduando em Medicina pela Universidade do Vale do Sapucaí (UNIVÁS) (Graduando em Medicina).

<sup>2</sup> Doutorado em Radiologia Clínica pela Universidade Federal de São Paulo-UNIFESP. Mestrado em Bioética pela Universidade do Vale do Sapucaí - UNIVÁS/MG. (Médico Radiologista. Professor Auxiliar na Disciplina de Radiologia e Diagnóstico por Imagem na UNIVÁS/MG, e Professor de Pós-Graduação no Mestrado de Bioética da UNIVÁS).

<sup>3</sup> Doutorando pela Fundação Antônio Prudente - AC Camargo Cancer Center (2013) e Mestrado em Patologia pela Universidade Federal de São Paulo - UNIFESP-EPM (2007). (Médico Anatomopatologista do Hospital das Clínicas Samuel Libânio (HCSL) da UNIVÁS. Professor Auxiliar de Ensino na Faculdade de Ciências da Saúde da UNIVÁS).

<sup>4</sup> Graduando em medicina pela UNIVÁS, Pouso Alegre, MG. (Graduando em Medicina).

#### Institution:

Universidade do Vale do Sapucaí, Campus Central.

#### \* Corresponding Author:

João Paulo Luvizotto  
Alcântara de Pádua  
E-mail: jplap1993@gmail.com

Submitted on: 07/06/2017.

Approved on: 23/11/2017.

## INTRODUCTION

The colonic lipomas are benign and non-epithelial tumors, located typically in the submucosa and in rare cases in the subserosa of the large intestine, and may, in some circumstances, affect the entire gastrointestinal tract. Have a low incidence, with variation of 0.2% to 4%, according to the literature. Represent the second benign neoplasia more frequent in the colon, excluding polyps.

Are usually asymptomatic; however when its size exceeds 2 to 3 cm can generate symptoms such as abdominal pain, presence of blood in stool and change of habit intestinal. Tumors "giants" may cause intestinal obstruction with intussusception of the colon, and in some cases it is reported the elimination of spontaneous tumors.<sup>1-6</sup>

The clinical diagnosis is difficult and depends on the size and location of the tumor. Imaging tests such as ct, mri and/ or ultrasound assist in the diagnosis.<sup>7</sup>

## CASE REPORT

L. A. D., 53 years, male, reports crampy abdominal on the left flank and left iliac fossa for 15 days, which evolves to toughness the abdominal with subsequent diarrhoea, featuring liquid stool with mucus and streaks of blood, as well as the presence of flatulence; denies fever. It was the use of Albendazole 400mg there were 5 days, ciprofloxacin hydrochloride 500mg 2 times a day, and Nitazoxanide as empirical treatment of enteroinfections and verminoses.

At the clinical examination, in good condition, afebrile, anicteric and acyanotic. On physical examination, the abdomen hardened in the left lower quadrant without bulging or retractions, with pain type acute hyperalgesia with deep palpation, of the type in the left iliac fossa (FIE), without irradiation, as an attenuating factor to the compression of the left iliac fossa.

Ischemia, diverticular disease, and neoplasia as a differential diagnosis was suggested by the medical service due to the characteristics of the patient's pain. The conduct that followed was the realization of a total abdominal tomography to possibly confirm the diagnosis, having as result an image suggestive of colonic lipoma; and a colonoscopy was performed under sedation.

The last one made possible the visualization of the lesion suggestive of lipoma in the upper rectum, and the pedicle and mucosa did not present signs of vascular change. Next to the lesion, we found a small hole in the mucosa, suggestive of fistula, which had constant pain symptoms, located in the perianal region, with worsening factor when sitting and defecating, without improvement factor; in addition there was perianal hyperemia and presence of pus. (Figures 1 and 2).

The material resected was sent to study pathological where evident nodular structure, lobulada, soft-tone brown with yellowish portions and the following dimensions: 7,0 x 5,0 x 4,5 cm. (Figure 3).

The histological sections showed to be neoplasia mesenchymal benign composed of mature adipocytes interspersed by delicate septa fibrous and blood vessels located in the submucosa. (Figures 4 and 5).

With the confirmation of colonic lipoma, was performed a colostomy concomitant to laparotomy, and the patient was discharged in good general condition.



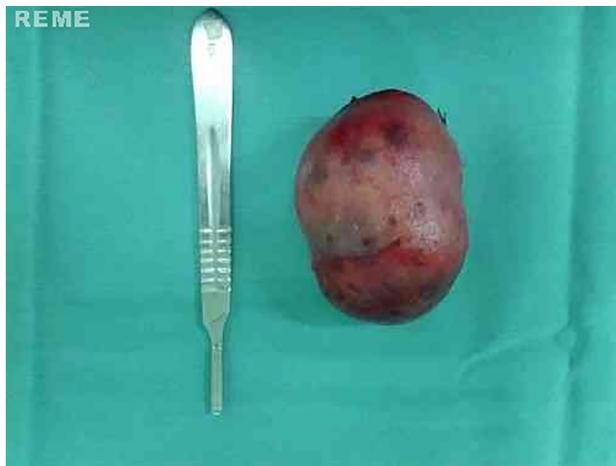
**Figure 1.** Axial computed tomography (CT) scan with contrasting evidence showing expansive formation with fat density measuring 6.9 x 4.9 cm in the left iliac fossa inside the descending colon



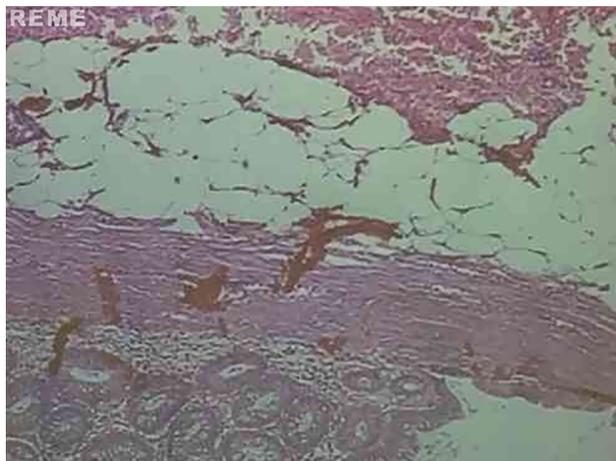
**Figure 2.** Coronal Computed Tomography section with contrasting evidence of expansive formation with fat density measuring 5.4 x 4.8cm in the left iliac fossa inside the descending colon.

## DISCUSSION

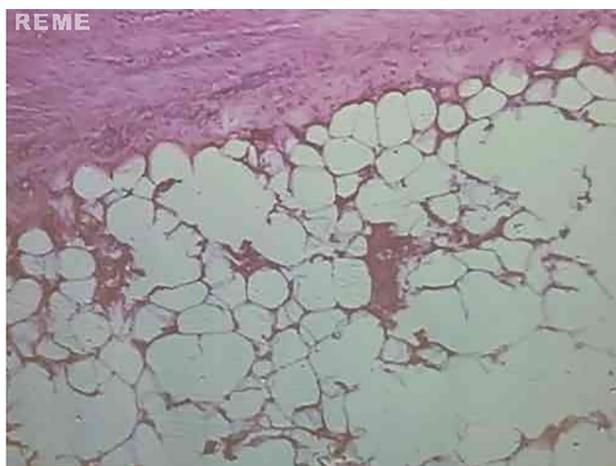
The lipomas are structures neoplastic benign of the yellow fat, rarely delimited by a fibrous capsule. Its distribution is more common in the ascending colon, but can



**Figure 3.** Descrição Macroscópica Lipoma Colônico- Macroscopic Description Lipoma Colônico  
Estrutura nodular, de dimensões 7,0 x 5,0 x 4,5 cm, tonalidade pardo clara; aos cortes é macia, pardo-amarelada e homogênea.



**Figure 4.** Benign neoplasm consisting of mature adipocytes without nuclear atypia interspersed with delicate blood vessels.



**Figure 5.** Proliferation of mature adipocytes in the submucosa.

also be found in the cecum, transverse colon and descending colon. Are mostly submucosal and usually unique. Ivekovic et al.<sup>8</sup> analyzed 5563 endoscopies, in which only 11 have been identified colonic lipoma (0.02%); of these, 6 were men (55%) with a mean age of 68 years. Colonoscopy was

indicated for these patients for changes in bowel habits 7 of them (64%), carcinoma colorectal in 3 (27%), and gastrointestinal bleeding in 1 patient (9%). The lesions were found in the hepatic flexure in 4 patients (36%), in the cecum or ascending colon also in 4 patients (36%), sigmoidal in 2 patients (18%) and in transverse colon in 1 patient (9%).

The symptoms are related to their size. Lipomas up to 2 cm in diameter are asymptomatic, and the larger ones can produce symptoms such as abdominal pain, stool tarry, change of habit, bowel and weight loss. Can still present complications that include bleeding and bowel obstruction, and more commonly the intussusception.<sup>9-12</sup>

The diagnosis of colonic lipoma is established by the association of clinical, proctologic and colonoscopic examination, and imaging tests (ultrasound and CT scan of the abdomen), with subsequent confirmation by histopathological study of the specimen surgical.

The treatment depends on the location, symptoms and size of lipoma. Lesions smaller than 2 cm are treated by endoscopic resection, combined with the ultrasonography endoscopic to reduce the risks of drilling; at present, however already there are reports of resection of lipoma, colonic giant by endoscopy for the paper “loop-and-let-go”, as reported by Ivekovic et al.<sup>8</sup> Surgical treatment is recommended for lesions larger than 2 cm, and more commonly performed excision of the lesion, partial colectomy and hemicolectomy.<sup>13</sup>

## CONCLUSION

Due to the symptoms of pain, intestinal alteration and gastrointestinal bleeding, the patient sought the service, which through anamnesis, clinical examination and complementary examinations, suggested a colonic lipoma hypothesis, being diagnosed as having no upper rectum by colonoscopy. It is important to note a dimension of the present tumor (7.0 x 5.0 x 4.5 cm), which could be a cause of abdominal pain by the patient, concomitant with intussusception; However, because it is an acute pain the pain is believed to be more evolutionary of the intussusception, assuming that the evolution of the lipomas is chronic.

The treatment of choice for the surgical one due to the size of the tumor, which generated clinical manifestations that needed rapid intervention, due to possible complications.

In this report, we can see that the found data are consistent with the literature reviewed.

## REFERENCES

1. Aytac B, Yerci Ö, Gürel S, Ferik Z. Colonic Lipomas Mimicking Colon Cancer. *Turk J Pathol.* 2010;26(3):196-9.
2. Zhang X, Ouyang J, Kim YD. Large ulcerated cecal lipoma mimicking malignancy. *World J Gastrointest Oncol.* 2010;2(7):304-6.
3. Nallamothu G, Adler DG. Large colonic lipomas. *Gastroenterol Hepatol (NY).* 2011;7(7):490-2.
4. Ghidirim G, Mishin I, Gutsu E, Gagauz I, Danch A, Russu S. Giant submucosal lipoma of the cecum: report of a case and review of literature. *Rom J Gastroenterol.* 2005;14(4):393-6.
5. Jiang L, Jiang LS, Li FY, Ye H, Li N, Cheng NS, et al. Giant submucosal lipoma located in the descending colon: a case report and review of the literature. *World J Gastroenterol.* 2007;13(42):5664-7.

6. Ryan J, Martin JE, Pollock DJ. Fatty tumours of the large intestine: a clinicopathological review of 13 cases. *Br J Surg.* 1989;76(8):793-6.
7. Pereira JM, Sirlin CB, Pinto PS, Casola G. CT and MR imaging of extra-hepatic fatty masses of the abdomen and pelvis: techniques, diagnosis, differential diagnosis, and pitfalls. *RadioGraphics.* 2005;25(1):69-85.
8. Ivekovic H, Rustemovic N, Brkic T, Ostojic R, Monkemuller K. Endoscopic ligation ("Loop-And-Let-Go") is effective treatment for large colonic lipomas: a prospective validation study. *BMC Gastroenterol.* 2014;14:122.
9. Bromberg SH, Zampieri JC, Cavalcanti LAF, Waisberg J, Barreto E, De Godoy AC. Lipomas colorretais: correlação anatomoclínica de 29 casos. *Rev Assoc Med Bras* 1997;43(4):319-25.
10. Rogers SO Jr, Lee MC, Ashley SW. Giant colonic lipoma as lead point for intermittent colo-colonic intussusception. *Surgery.* 2002;131(6):687-8.
11. Cruz GMG, Oliveira AT, Rodrigues JVL. Lipomas colorretais: apresentação de 15 casos pessoais e revisão da literatura. *Rev Bras Coloproct.* 1997;17(1):32-43.
12. Garcea D, Lucci E, Lattuneddu A. Occlusion par invagination sur un lipome colique. *J Chir.* 2002;139(6):351-2.
13. Paškauskas S, Latkauskas T, Valeikaitė G, Paršeliūnas A, Svagždys S, Saladžinskas Z, et al. Colonic intussusception caused by colonic lipoma: a case report. *Medicina (Kaunas).* 2010;46(7):477-81.