

CASE REPORT**SUBSEROSAL SIGMOID LIPOMA: A CASE REPORT AND REVIEW OF THE LITERATURE**Daniel Zemenfes, MD^{1*}, Zelalem Semegnew, MD¹**ABSTRACT**

Colonic lipoma is a rare non-epithelial mesenchymal tumour which is the second most common benign tumour of the colon excluding hyper-plastic polyps. It is often small and asymptomatic but may become symptomatic and mimic malignant lesions as the size increases. This is a case report of a 68 year-old female patient who presented with lower abdominal pain, constipation and rectal bleeding of one year duration. Colonoscopy revealed a sessile tumour 40 cm from the anal verge with an inconclusive histology. After incising and removing the lipoma, the redundant mucosal fold was then resected. The patient recovered completely and was discharged on the fifth postoperative day.

Keyword: Colonic lipoma

INTRODUCTION

Gastrointestinal lipomas are single, benign non-epithelial tumors which grow slowly. It is the second most frequent benign tumor after adenomas of colon (1,2). Although colonic lipomas are the most common types, they are unusual benign tumors (1,3-6). Ninety percent of colonic lipomas lie in the submucosa while the remaining subserosal lipomas make up less than 10% (1,2,6-8). Clinical and postmortem studies reveal an incidence of lipoma that varies between 0.2 and 4.4 % (1,3,6,8). The elderly are more likely to be affected with a peak incidence during the fifth to sixth decades of life (1,3,4,8-10). Women are more commonly affected (3,4,10-12). Most of the colonic lipomas are asymptomatic and commonly detected during colonoscopy, surgery or autopsy (1,3,9-11).

She was having episodes of rectal prolapse and was treated with different medications at a local health centre. The examination disclosed an emaciated lady with unremarkable physical findings. Hct and serum albumin were 40% and 2.8 g/dl, respectively. Organ function tests were within normal limits. Colonoscopy demonstrated a mass 40 cm from the anal verge, and the biopsy was suspicious for severe dysplasia.

Laparotomy revealed a 6x4.5x1.5 cm subserosal soft mass over the sigmoid colon. There were no adjacent lymph nodes and the liver appeared normal. A transverse incision was made over the sigmoid colon over the lump which was later dissected out without opening the lumen. The mass was comprised of yellowish soft fatty tissue with benign appearance.

Wedge resection of the redundant mucosa was done. Microscopic examination showed bland adiposities with thick walled blood vessels and a few fibroblasts which is consistent with a lipoma.

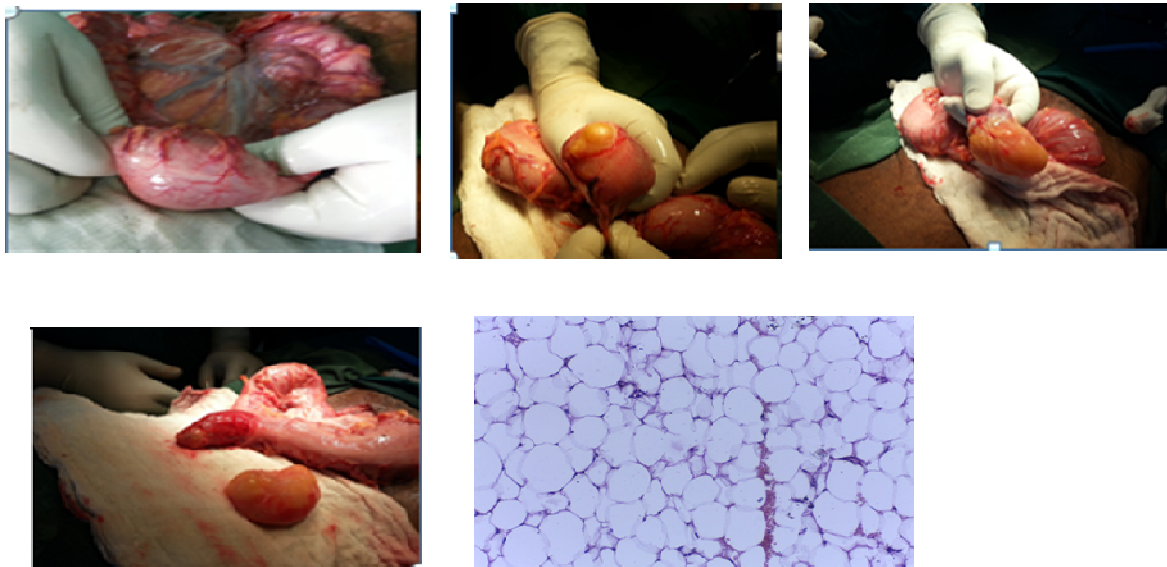
CASE REPORT

A 68 year-old female patient from Sendafa was admitted to our hospital with the diagnosis of colorectal cancer after she presented with a history of constipation for the previous 6 months associated with intermittent bleeding per rectum and abdominal discomfort.

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Fig 1. Intraoperative view and microscopy of the colonic lipoma.



DISCUSSION

Most colonic lipomas are right-sided accounting for nearly 90% of cases and rarely are found at the descending or sigmoid colon or rectum. The majority of colonic lipomas present as single lump while 10% are multiple (1,9,10). The most frequent type of lipoma is submucosal (90%), while subserosal lipoma accounts for 10%. Although many studies showed lipomas occur predominantly among women, others observed an equal distribution among both sexes (1,3,4,9,10). The rarity of the cases makes it difficult to reliably predict the distribution of the disease among women and men.

Colonic lipoma is asymptomatic or mildly symptomatic; in most instances it is detected incidentally in examinations for other purposes. More than 75% of colonic lipoma become symptomatic when the size is larger than 2 cm (4,8,12). Moreover, symptoms appear at an early stage when the growth is towards the luminal side while presentation may be delayed if growth is towards the serosal side (3,13). The most common symptoms of colonic lipoma include abnormal bowel habits, abdominal pain, diarrhea, rectal bleeding and episodes of intussusception or intestinal obstruction (1,8,10,12).

Symptomatic presentations often mimic malignancy causing diagnostic challenge (1,3,7-9). A lipoma should be suspected whenever a huge smooth polyp is detected in the colon (2).

Colonoscopy, endoscopy and barium enema are useful in making the diagnosis of colon lipomas (9). CT scan and magnetic resonance imaging are considered to be the best imaging methods for diagnosis of lipoma (8,10).

A thorough assessment and careful consideration should be made to choose the best possible management. Although preoperative imaging is helpful for evaluation, discussion and review of investigations with a team comprising an endoscopist, radiologist, pathologist and oncologist may aid the pre-operative diagnosis and offer the best results.

There is wide consensus in using open surgical interventions to treat lipomas at any location or any type and size with associated complications to relieve symptoms and properly explore the peritoneal cavity to rule out malignancy. Although endoscopic resection is also recommended for symptomatic lipoma (1,3,8,12), it is considered controversial and unreliable partly because fatty tissue is an inefficient conductor of electric current, making electrocautery challenging (2,6,9,12). The definitive diagnosis should be made on the basis of histopathological examination of the resected specimen (1,3,4,8,10).

Conclusion: Colonic lipomas mainly occur in the elderly and cause gastrointestinal bleeding with anemia, intestinal obstruction, abdominal distention and intussusception, mimicking malignancy. Appropriate preoperative radiological and colonoscopy evaluation is essential to reach a preoperative diagnosis so as to avoid unnecessary extensive resections. Endoscopic polypectomy and local resection are preferential management options in majority of the cases depending on the size and type of lipoma.

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