

proliferating vascular component set in a fibrous stroma. The former is characterized by blood vessels of different size and smooth muscle content. The stroma consists of plump spindle, angular or stellate shaped cells and a varying amount of collagen fibers. Immuno histochemical analysis has shown that stromal cells have strong cytoplasmic reactivity for vimentin and are generally immunonegative for smooth muscle actin. For an experienced pathologist although accurate diagnosis of an angiofibroma is not too difficult, but when its location is an extremely rare one, a methodic evaluation and a high index of suspicion are essential in establishing the proper diagnosis and treatment.

Case Report

Intussusception due to Jejunal Lipoma: A Case Report.

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Abstract: Benign tumors of the small bowel are rare clinical entities. These often remain asymptomatic throughout life. Despite comprising 75% of the length and 90% of the surface area of the gastrointestinal tract, the small bowel harbors relatively few primary neoplasms and fewer than 2% of gastrointestinal malignancies. We report a case of jejunal lipoma that became symptomatic due to intermittent obstruction episodes and caused intestinal obstruction due to intussusception. Lipoma was removed and the patient's postoperative period was uneventful. In this case report, the diagnosis and management of intestinal lipomas are discussed along with a literature review.

INTRODUCTION

Lipomas constitute about 10% of the gastrointestinal benign tumours¹ and there are limited scattered cases in the literature of intestinal lipomas presented with bleeding², and bleeding and intussusceptions³. Symptoms due to obstruction in adults tend to be chronic or intermittent and include pain, constipation, weight loss, or a palpable abdominal mass at physical examination. Intussusceptions are much less common in adults, who account for 10% of all intussusceptions, and unlike in children, a lead point is usually found. In adults, intussusceptions may be ileocolic, colocolic, enteroenteric and there is no anatomic predilection. The lead points of adult intussusceptions that involve the colon are usually malignant (carcinoma, lymphoma), whereas those that involve the small bowel tend to be benign (lipoma, polyp, Meckel diverticulum, from lymphoid hyperplasia secondary to viral infection). The clinical presentation of patients with intussusceptions also differs in these two age groups. Children present acutely with colicky abdominal pain, vomiting, and bloody stools that look like currant jelly, and often a palpable mass. Symptoms in adults tend to be more chronic or intermittent and include pain, constipation, weight loss, or a palpable abdominal mass at physical examination⁴. The CT findings in intussusception are usually pathognomonic. The CT features include: (a) A target like or sausage like mass, depending on the angle of the beam relative to the intussusception, in which the inner central area represented by its mesenteric fat and associated vasculature, all of which are surrounded by the thick-walled intussusciens. (b) Oral contrast

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material trapped between the opposing walls of the intussusceptum and intussusciens. (c) A soft tissue mass secondary to the intussusception, possibly with the accompanying lead point, telescoping into the intussusciens⁵.

Here we report a case of small intestinal (jejuna) lipoma which presented with intestinal obstruction caused due to intussusception and review some aspects of diagnosis and treatment.

CASE REPORT

A 22 years old male patient was admitted to the emergency department with a history of pain abdomen, fullness and nausea with few episodes of vomiting for 4-5 days. He gave history of intermittent abdominal pain, distention aggravated by eating and episodic hematochezia for last 8 -10 months. There was no past history of any previous operation. There was no family history of gastrointestinal disorders or neoplasms. Bowel sounds were slightly increased. On physical examination, the abdomen was without palpable masses, tenderness or rigidity. Mild abdominal distension was noticed. Digital examination showed that the rectum was empty of stool. Proctologic examination revealed no signs of hemorrhoids, fissure or fistula. Examination of the other systems was normal. Plan X-ray abdomen and results of routine laboratory tests were within normal limits. Abdominal computerized tomography (CT) scan showed a fat density (-85 to -95 HU) lesion measuring approximately 5 cm in the lumen of the jejuna loops with evidence of intussusceptions (Fig. 1,2,3). On exploratory laparotomy, about 15 cm from duodeno-jejunal junction a mass was felt in the lumen of small gut which had caused increased in diameter of small gut. On enterotomy a polyp like mass was seen filling the lumen of jejunum and it was arising from mesenteric border of the gut and was submucosal (Fig. 4,5). The affected segment of jejunum was resected with an end-to-end anastomosis. The

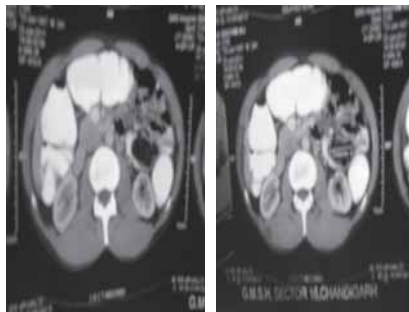


Fig. 1

Fig. 2

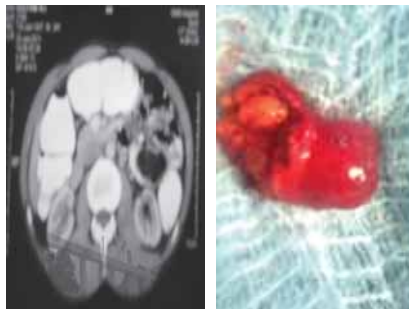


Fig. 3

Fig. 4



Fig. 5

macroscopic appearance was typical of a lipoma and it measured 6 x 5 cm in size. The patient's post-operative period was uneventful and was discharged on 5th post-operative day.

DISCUSSION

Polyps, lipomas, fibroma and leiomyoma are known to be the commonest type benign tumours in the small bowel. Lipomas account for 10-12% of all benign tumours of the small intestine. They represent 20-30% of all lipomas affecting the gastrointestinal tract and are more frequent in males. More than 50% arise in the ileum. Intestinal lipomas are usually solitary but may be multiple. Their size ranges between 1 and 6 cm but they may occasionally reach a size up to 30 cm. Most small bowel lipomas arise in the submucosa and tend to grow into the lumen. Some endoluminal lipomas become more and more elongated and even pedunculated and may then cause intussusception. Lipoma is localized more frequent in the colon than in the small bowel and stomach. Colon lipomas constitute 65% to 75% of cases of gut lipomas. Small intestinal lipomas are usually single and they are multiple in about 10% to 15% of cases. Ileum is the commonest site of the small bowel lipomas, followed by jejunum and duodenum. They occur mainly in elderly patients, they are benign in nature but regarding the age and symptoms of these patients, malignant lesions

are often considered in distinctive diagnosis. Therefore, because of these characteristics, they are mostly removed to exclude the diagnosis of malignant lesions⁶⁻⁸.

The majority of lipomas are submucosa l (90%), although they can also be subserosal or intramuscular. Less than one-half of the patients who have intestinal lipomas become symptomatic. One of the most common types of presentation is intussusception with small bowel obstruction. Surgical removal is indicated if lipomas are symptomatic or to perform their histological examination since liposarcomas must be ruled out. Endoscopic removal entails a risk of perforation or bleeding due to submucosal origin of the majority of the lipomas. The size of the stalk is of greater importance than the diameter of the lipoma itself when patient is evaluated for endoscopic resection. Laparoscopic resection is also a viable alternative to open excision in selected cases. Barium enema and endoscopy are not useful for the diagnosis of jejunal or ileal lipomas, although they are basic measures for investigating colonic or duodenal lipomas. However abdominal ultrasound may be useful in some cases of mid-and terminal ileum tumors, CT scan has become the first imaging modality after plain x-ray in evaluation of patients often presenting with nonspecific or subacute abdominal symptoms. Lipomas appear spherical or ovoid with sharp margins and absorption densities of -40 to -120 Housfield Units (HU) typical of the fatty composition. CT generally shows thickening of the jejunum and "target sign" typical for invagination, and homogeneous fat density mass image almost filling the lumen. CT findings in intussusception are usually pathognomonic, including a target-like mass, oral contrast material trapped between the opposing walls of the intussusceptum and intussusciptens. Although differentiating a benign lipoma from a malignant lesion before the operation is essential for the preference of surgical method, CT scan has some limitations for small size colonic lipomas. Surrounding soft tissue or intraluminal material may create an artificial increase in CT density values⁹⁻¹⁰. In colonic or duodenal lipomas, endoscopic ultrasound may help for this differentiation, but in most cases, the precise diagnosis is arrived at only after histological examination of the resected specimen.

Although intestinal lipomas are rare, they should be kept in mind when evaluating the adult patient with intermittent abdominal symptoms. They should be removed because they can cause symptoms such as obstruction or bleeding and usually a histological evaluation is indicated in intestinal mass to exclude the possibility of malignancy.

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