CASE REPORT

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Giant Intraperitoneal Lipoma of the Cecum

Çekum Kaynaklı Dev İntraperitoneal Lipom

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ÖZET

Kolon lipomları genel olarak asemptomatik ve nadir rastlanan benign, submukozal yağ dokusu kökenli tümörlerdir. Kolon lipomları genellikle çekum ve çıkan kolonda ortaya çıkarlar. Bu lezyonlar genellikle tesadüfen tespit edilirler. Büyük kolon lipomları malignite ile karıştırılarak gereksiz yere geniş cerrahi operasyonlara yol açabilir. Bu olgu sunumunda karın ağrısı ile hastanemize başvuran büyük boy sesil lipomlu 64 yaşında erkek hasta bildirilmektedir. Hastaya laparotomi ve eksizyon uygulanmış, lezyon intraperitonal sesil lipom olarak tanı almıştır.

Anahtar Kelimeler: İntraperitoneal lipom, Çekum, Benign

ABSTRACT

Colonic lipomas are uncommon, benign, submucosal adipose tumors that are usually asymptomatic. Colonic lipomas usually occur in cecum and ascending colon. These lesions are usually detected incidentally. Large colonic lipomas can be mistaken for malignancy, which may result in extensive surgical operations. We report a large size cecal lipoma in a 64-year-old man, who presented with abdominal pain. The patient underwent laparatomy and excision, the lesion was diagnosed as an intraperitoneal cecal lipoma.

Key words: Intraperitoneal Lipoma, Cecum, Benign

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Introduction

Colonic lipomas are uncommon, benign, submucosal adipose tumors that are usually asymptomatic. Lipoma of the colon may be detected incidentally at colonoscopy, surgery or autopsy.[1] Although colonic lipomas smaller than 2cm are usually asymptomatic, lesions >2cm are usually symptomatic.[2] Large colonic lipomas can be mistaken as malignancy, which may result in extensive surgical operations.[3] Various surgical treatment options can be taken in to account in colonic lipomas. Hereby we intended to present a case of a 13 cm giant cecal lipoma treated by laparatomy and excision in a 64 year old man suffering from abdominal pain.

Case Report

Herein, we report a 64-year-old man admitted to emergency room with right low quadrant abdominal pain history for10 days with episodes of tenesmus, nausea and vomiting. There was no loss of weight. Initial physical examination revealed right low quadrant tenderness, rebound and fullness without any masses. No hemorrhage was determined in digital rectal examination. There was no systemic fever. All routine laboratory tests were within normal limits. Ultrasound and computerized tomography showed minimal abdominal fluid and a 10-15 cm diameter mass in the right low quadrant. The differential diagnosis was plastron appendicitis with periappendicular abscess or neoplasia arising from cecum. The patient was admitted to emergency room at midnight. As there was no colonoscopy unit in the emergency, colonoscopy procedure could not be done and the patient was undergone to operation with acute abdomen signs. Inferior midline abdominal incision. was performed. Minimal intraabdominal serous fluid was observed. The appendix was normal. A giant intraperitoneal mass, puce in color, was detected adjacent to caecum in the right lower quadrant. There was no peritoneal adhesion to the mass. Nevertheless, the mass had an adhesive connection with the wall of the cecum near the ileaocecal valve. The mass was removed easily (Fig. 1) with no intestinal defect.

Figure 1. Intraperitoneal lipoma of the cecum.

Figure 2. Gray-white well encapsulated mass with smooth surface.

Gross pathologic examination revealed 13x9x6 cm gray-white well encapsulated mass with a smooth surface (Fig. 2) and hemorrhagic areas. Pathology confirmed the presence of mature adipose cells, consistent with lipoma. There was no carcinoma identified. The patient was discharged without any problem on postoperative day five.

Discussion

Lipoma is a benign tumoral lesion of the adipose tissue and can be presented anywhere in the body extremities, and even intraperitoneal cavity, although the latter is extremely rare.[1] The intraperitoneal lipomas were published as sporadical cases arising from more commonly ileal mesentery.[4] Colonic lipomas are uncommon mesenchymal tumours that are covered by fibrous tissue and formed by well differentiated adipocytes.[5] These tumours are more frequently seen in colon (64%) than stomach and small intestine. In colon, the most frequently involved areas are ileocecal valve and ascending colon.[5] Colonic lipomas arise in the

submucosa but occasionally extend into the muscularis propria or subserosa.[6] Usually, the lipomas are solitary, but can be multiple.[7] The median age at the time of diagnosis ranges from 50 to 69 years and there are no differences in sex prevalence.[8]

The etiology is not well-known, although increased incidences are reported in people who are obese, have hypercholesterolemia, diabetes mellitus, trauma history, or exposure to radiation or with familial tendency, however none of these were applicable to the present case.[1] The symptoms are not related to the involved segment of large bowel. Generally, a lipoma of less than 2 cm is usually asymptomatic, whereas 75% of lipomas exceeding 2 cm in diameter (size appears to correlate with symptoms) present with symptoms such as pain (55%), diarrhea, intermittent subacute obstruction of the colon, bleeding from the ulcerated tip of the lesion (40%) and may be the lead point for intussusceptions (5-7% in patients with large lipomas).[2] The clinical presentations are generally volvulus or chronicle abdominal pain.4,9 There was not intestinal volvulus in our patient but there was severe abdominal pain for ten days. The physical examination was not helpful on differential diagnosis in our patient as in the literature. Computerized tomography and/or magnetic resonance imaging can show intraabdominal mass but it is not specific for lipoma.[10] The definitive diagnosis is only endoscopic (barium enema is aspecific for round and regular filling defects). The characteristic findings include the mucosa being elevated over the lipoma with the biopsy forceps ('tent sign'), indentation of the lipoma with the biopsy forceps (so-called 'cushion sign' or 'pillow sign'), or the 'naked fat sign' where the fat can be extruded after removal or serial biopsy.[11]

Features that suggest a higher likelihood of malignancy include increased patient age, large lesion size, presence of thick septa, presence of nodular and/or globular or nonadipose mass like areas, and a decreased percentage of fat components.[12] Transformation to liposarcoma is exceedingly rare, described in only a few case reports.[13] Large colonic lipomas, can sometimes be mistaken for malignancy, which may result in extensive surgical operations.[3] Surgical resection is recommended for larger lipomas to relieve the symptoms or exclude malignancy.[14] If the preoperative diagnosis of colonic lipoma can be made correctly, the extent of surgery may be appropriately limited.[15] In our case, although the length of the tumour was >13 cm, surgery as simple excision without resection was well performed.

As a result, although colonic lipomas are rare and benign mesenchymal tumours, improper preoperative diagnosis may cause huge unnecessary abdominal surgery. To hinder unnecessary grand resection, colonic lipoma should be kept in mind while evaluating the patients before the surgery.

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