Answer

Intussusception Caused by Lipoma of the Colon

Although lipomas of the colon are considered the second most common benign nonepithelial tumors of the colon and rectum, they are rare. From July 17, 1997, until October 2004, we encountered 7 cases of lipomas of the colon. The patients ranged in age from 51 to 64 years (median age, 60 years) and included 3 men and 4 women. Their clinical presentation included rectal bleeding (n=2), pain in the right iliac fossa (n=3), pain in the left iliac fossa (n=1), diffuse upper abdominal pain (n=1), and symptoms and signs of intestinal obstruction (n=1). Their diagnosis involved flexible sigmoidoscopy, colonoscopy, barium enema, computed tomography, and magnetic resonance imaging. Their management involved right hemicolectomy (n=1), local excision (n=2), and observation (n=1).

In general, colonic lipomas are more common in women than men and occur most often in the fifth and sixth decades of life. The incidence is estimated from 0.03% to as high as 4.4% in some series. Most lipomas are silent and often detected incidentally by colonoscopy or barium enema. The patients may have intussusceptions as demonstrated by magnetic resonance imaging, change in bowel habits, or simple mechanical obstruction. Barium enemas are not diagnostic and can miss lipomas smaller than 2 cm; however, they are mandatory to rule out malignant lesions. On barium study, lipomas are typically round or ovoid, sharply defined, smooth, filling defects. Colonoscopy, on the other hand, can readily show lipomas since most of them are submucosal. The lipomas typically appear as smooth, spherical, slightly yellowish polyps of variable size (0.5 to >5 cm) with either a broad base of attachment or a thick pedicle. The mucosa is usually normal; however, it may ulcerate. Probing of the polyp will give you the cushion sign (pillow-like indentation), and grasping the overlying mucosa with biopsy forceps gives the tenting effect. Biopsy may result in an extrusion of yellow fat, the “naked fat” sign. If a lipoma is removed, it will float in formalin fixative. Computed tomography can be used to identify lipomas of the colon easily by their homogeneity, and it can be used to easily differentiate between liposarcomas by showing absence of heterogeneity and areas of increased density. Liposarcomas of the colon are, however, extremely rare. Recently, computed tomography colonographic examination (virtual colonoscopy) has been performed to detect colonic lipomas.

Seventy percent of colonic lipomas are localized in the right colon, followed by localization in the transverse colon and then the descending colon, an opposite distribution in comparison with adenocarcinoma and adenomatous polyps. Colonic lipomas are usually encapsulated submucosally or are occasionally subserosal, and they can also be found in the ileum, duodenum, and jejunum (in decreasing order of frequency). There are variable reports of incidents of multiple lipomas in the colon, the highest incidence being 7 of 20 cases.

Perhaps the greatest clinical significance of lipomas lies in confusing them with adenomatous polyps or other serious pathological abnormalities. Theoretically, lipomas should be removed only if they cause symptoms; however, there is no sure method short of excision for confirming the diagnosis.

The surgical management of lipomas is in the form of colotomy and enucleation or excision. Resection, however, is indicated in the presence of intussusception. Snaring of lipomas with a 1.5- to 3.0-cm diameter has been advised by Papp and Haubrich. On the other hand, Bar-Meir et al described safe endoscopic removal of large 5-cm lipomas. The risk of perforation rises with broad-based polyps, and in a recent series, 43% perforation rate was found. Surgical removal, preferably laparoscopically, has been advocated for lipomas larger than 2 cm in diameter. Endoscopic removal of small lipomas is generally safe but rarely indicated.

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REFERENCES