

Unusual Presentation of Colonic Lipomas

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Key words: colonic lipoma, polyp, colonoscopy, polypectomy

IMAJ 2000;2:780-781

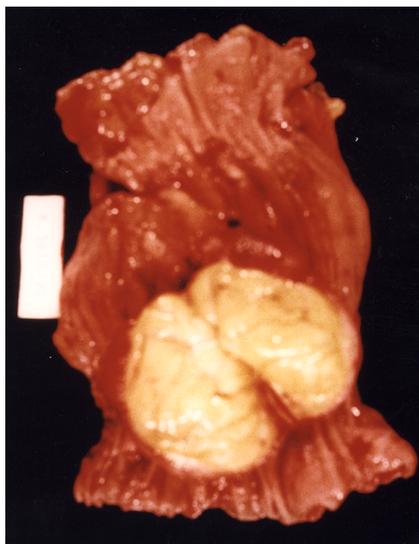
Lipoma is the second most common colonic tumor after adenomatous polyps. The incidence in autopsies is 0.2–0.8%. Ninety percent of colonic lipomas arise in the submucosa and the rest are subserosal [1]. In most cases these tumors are incidental findings at colonoscopy and of no clinical consequence. We describe two patients with obstructive symptoms; both had huge colonic lipomas with similar endoscopic appearance.

Case Description

Patient 1. A 34-year-old man was seen because of crampy abdominal pain in the left lower quadrant and rectal bleeding of 6 weeks duration. He gradually became constipated. He underwent colonoscopy and a 6x3 cm polyp was seen in the descending colon next to the splenic flexure. The polyp was firm and smooth and sat on a wide short pedicle with bluish-red discoloration. Biopsies revealed normal colonic mucosa. The size of the polyp and its sessile appearance prompted the decision to perform the polypectomy in the operating room and under general anesthesia. At colonoscopy the polyp was identified and easily snared. The snare was tightened over the wide pedicle and a high power coagulation up to 60 watts was applied using pure and blend coagulation current (Force20, Valleylab, Pfizer, USA). The current was applied for a total of 5 minutes, but the polyp could not be resected. The mechanical force applied during the attempted polypectomy caused the plastic sheath of the snare to break at its distal end. An attempt to remove the wire from the polyp was unsuccessful. The snare was cut next to the

handle and both the handle and the colonoscope were removed. Laparotomy was performed and a short segment of colon containing the polyp was resected. The postoperative recovery was uneventful. The polyp was very firm and smooth, and when it was cut had a yellowish color, characteristic of a lipoma [Figure 1]. Microscopic examination confirmed the diagnosis of lipoma.

Patient 2. A 38-year-old man complained of crampy abdominal pain of 3 months duration. He denied rectal bleeding or a change in his bowel habits. On colonoscopy, a 4x2 cm bluish-red very firm smooth polyp was identified in the mid-descending colon. A computed tomography scan revealed a hypodense mass suspected to be a lipoma. Snare polypectomy was not attempted and the patient underwent a laparotomy and segmental colectomy.



A huge polyp is seen in the resected specimen of patient 1. The polyp is composed of yellow tissue that represents fat.

This polyp was firm and smooth and when transected had the yellowish appearance of a lipoma. Histology confirmed the diagnosis. The postoperative recovery was uneventful.

Comment

We describe two patients with huge lipomas of the descending colon, both presenting with obstructive symptoms and one with rectal bleeding. Both were localized in the descending colon and had a similar appearance on colonoscopy. Lipomas are usually asymptomatic, but when larger than 2 cm they tend to cause symptoms as pain, change in bowel habits and rectal bleeding [1,2]. Most colonic lipomas are located in the ascending colon. The peak incidence occurs in the fifth to sixth decade and affects predominantly women. Our patients were both young males and their tumors were located in the descending colon. It has been proposed that typical signs may predict the diagnosis of lipomas in the colon. These include the “cushion sign,” which is indentation of the tumor with a closed biopsy forceps [3,4]; the “naked fat sign,” a protrusion of fat at the biopsy site [5]; and the “tenting sign” in which the mucosa may be grasped with the biopsy forceps and pulled up, tenting it away from the mass [3]. All these suggestive signs were carefully assessed and not observed in the cases presented. Moreover, the typical yellowish appearance of lipoma was not seen in our two patients.

A striking feature in patient 1 was the firmness of the lesion and the inability to resect it endoscopically,

even with high current. A possible explanation may have to do with impaired conductivity through fat.

A lipoma should be sought whenever a huge smooth polyp is identified in the descending colon. Further verification can be obtained with the help of CT, where there is a uniform hypodense polyp. On CT, absorption densities of -80 to -120 Hounsfield units confirm the fatty composition. In such a case the polyp should be re-

moved either directly by surgery or by colonoscopy in the operating room with the patient ready for surgery.

References

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