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Case Report

Ileal Lipoma Presenting As Adult Intussusception: Preoperative Diagnosis on CECT - Case Report and Review of Literature

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ABSTRACT

Ileal intussusception in adults is rare. Its incidence is for less than 5% of all cases of intussusceptions and almost 1%-2% of bowel obstruction. The child to adult ratio is more than 20:1. We report a rare case of ileoileal intussusception in an elderly lady secondary to an ileal Lipoma where diagnosis of ileal Lipoma was done preoperatively based on radiological images.

Key words: Intussusception, Lipoma

INTRODUCTION

Intussusception is uncommon in adults accounting for 1-2% of all adult intestinal obstructions. [1] The classic clinical trial of conventional intussusception consisting of abdominal pain, a palpable sausage-shaped mass, and heme-positive stools is rarely present. The CT findings are sufficiently characteristic to warrant a confident diagnosis. Though surgical resection is mandatory, the extent of resection and whether the intussusception should be reduced before resection is controversial. In view of few reported cases in literature, we report our experience in adult intussusception.

CASE REPORT

A 60-year old lady presented with two episodes of sudden severe colicky abdominal pain more on the right side and associated with vomiting. The symptoms got aggravated by meals and were relieved after few hours.

There was no weight loss or bleeding per rectum. On examination, the abdomen was soft with localized mild deep tenderness in the right iliac fossa and no palpable abdominal masses.

Plain abdominal X-ray showed dilated small bowel loops. The Ultrasonography (USG) abdomen revealed ileo-ileal intussusception secondary to mural lesion in the terminal ileum. Computed tomography (CT) scan of the abdomen and pelvis revealed ileo-ileal intussusception. CT images revealed a leading point that was a fat density lesion (3 cm x 3 cm in the terminal ileum suggestive of ileal lipoma as shown in Figure1.

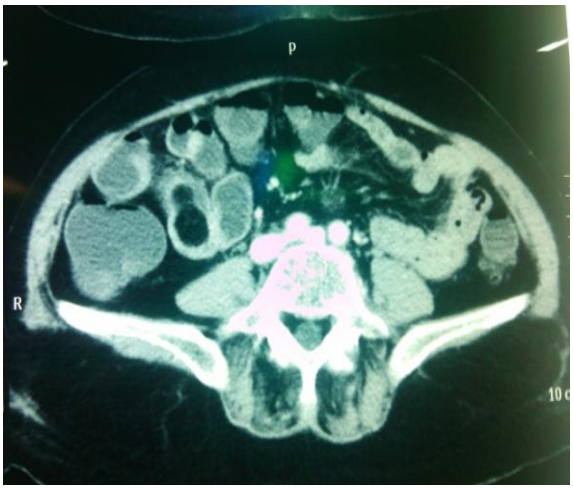

Figure 1:CT Scan showing ileallipoma .

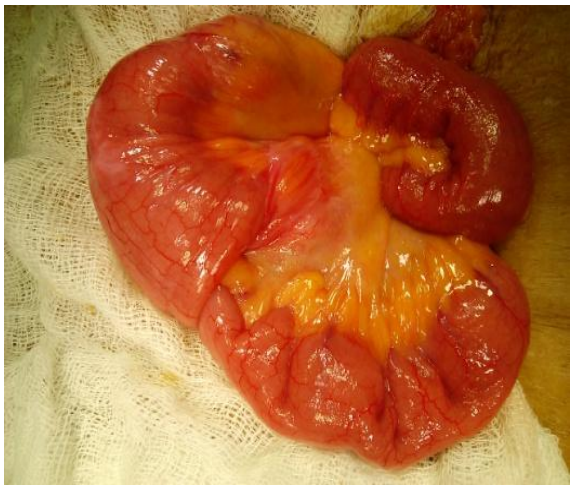

Figure 2 : Intraoperative photograph showing ileoileal Intussusceptions.

At laparotomy, ileoileal intussusception was found as shown in Figure 2.

After reduction of the intussusception the leading point was seen to be an intramural ileal lipoma about 3cm in diameter situated on the antimesenteric border of the terminal ileum as shown in Figure 3

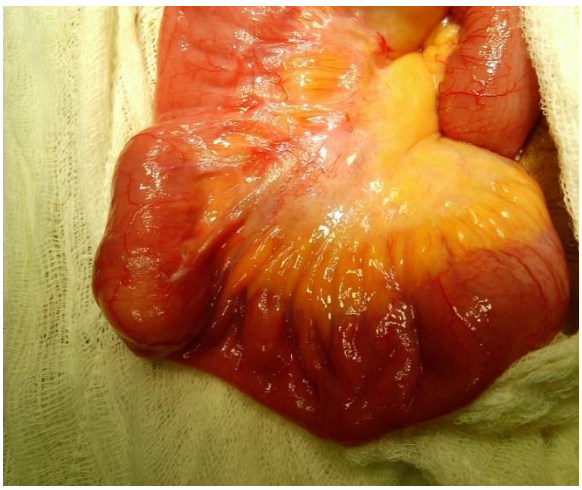

Figure 3: Intraluminal lipoma seen after reduction of intussusceptions.

Wedge resection of the bowel with lipoma was done without division of the mesentery. The patient had an uneventful postoperative recovery. The histopathology report confirmed the lipoma without any evidence of dysplasia or malignancy.

DISCUSSION

Adult intussusception is a rare disease that constitutes approximately 5% of all intussusceptions and it accounts for 1-2% of all adult intestinal obstructions.[1] It differs from childhood intussusception in its presentation, cause and treatment. In 90% of the adult intussusceptions, a predisposing lesion is identified contrary to intussusception in the paediatric population and requires surgical resection.[1]

Neoplasms are the most frequent causes of adult intussusception, and gastrointestinal lipoma has been infrequently reported as its cause.[1] In adults, it is important to differentiate between small bowel and colonic intussusception. In 63% of cases of small bowel intussusceptions, a benign underlying lesion can be found. In comparison, a malignant etiology is the cause in 58% of cases of large bowel intussusceptions.[2] Lipomas can be diagnosed through conventional endoscopy, capsule endoscopy, barium studies and CT scan. Typical endoscopic features are a smooth, yellowish surface with pedunculated or sessile base.[3] "Cushion sign" and "naked fat sign" are the other endoscopic characteristic features described.[4] CT usually reveals a smooth, well-demarcated sausage-shaped mass and

presence of intussusception. In our case diagnosis of lipoma was made on finding a hypodense intraluminal lesion in the terminal ileum as shown in figure1. Associated intussusception can be confirmed on contrast enema ("crescent sign"), CT and magnetic resonance imaging (MRI).

Lipoma is the second most common benign tumors in the small intestine and account for 10% of all benign gastrointestinal tumors and 5% of all gastrointestinal tumors.[3] They are predominantly submucosal but occasionally they arise in the serosa. Most common site of gastrointestinal lipomas is the colon (65% to 75%, especially on the right side) followed by the Small bowel (20% to 25%) and occasionally in the foregut (< 5%).[3] Lipomas are largely asymptomatic. The majority of presenting features are either intestinal obstruction (as was seen in our case) or haemorrhage.

Capsule endoscopy and digital balloon endoscopy are newer means for diagnosing lipomas and are particularly helpful in cases involving small bowel lipomas.[4]

Laparotomy is mandatory, in view of the likelihood of identifying a pathologic lesion. Weilbacher et al[5] established the principle of resection without reduction whenever possible. This was based on a high incidence of underlying malignancy that could not be confirmed either preoperatively or intra-operatively. Recently, several reports have recommended a selective approach to resection. Eisen et al.[6] have reported that colonic lesions should not be reduced before resection because they most likely represent a primary adenocarcinoma. They have also reported that small bowel intussusception should be reduced only in patients in whom a benign diagnosis has been made preoperatively or in patients in whom resection may result in short gut syndrome The high number of malignant causes of colonic intussusceptions makes en-bloc resection the best option, because of the lower risk of perforation or spillage.[7] On the other hand reduction of the intussusception followed by an elective resection can be done for small bowel intussusceptions. The type of resection and anastomosis depends on the location, bowel wall integrity, and vascular supply.[8]

CONCLUSION

Adult bowel intussusception is a rare but challenging condition for the surgeon. Gastrointestinal lipoma is a rare pathology and its most common complications are invagination and obstruction. Preoperative diagnosis is usually missed or delayed because of nonspecific and often subacute symptoms. A high index of suspicion and appropriate investigations (USS, barium enema and CT scan) can result in prompt diagnosis.

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