Case Report

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A Rare Case of Multiple Ileal Lipoma in a Young Male

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Abstract

Background: Non-obstructive intussusception in adults is rare and is seen in less than 1 per 1300 abdominal surgeries. 95% of intussusception in adults usually presents as obstruction, commonly due to a pathological cause for the lead point.

Clinical Description: A 45-year-old young gentleman with non-radiating chronic intermittent abdominal pain for four to five years of duration without any significant weight loss. Clinical examination was non-specific with stable vitals.

Management: Ultrasonography of the abdomen and pelvis was done and it was reported to have ileocecal intussusception of approximately 10 cm. Contrast-enhanced computed tomography revealed an ileal lipoma as a lead point for ileocecal intussusception. The laparoscopic reduction was attempted and was ultimately manually reduced with resection of the lipoma, and the bowel was resected and anastomosed.

Conclusion: Though the diagnosis of adult intussusception is challenging at times, a surgeon should anticipate the diagnosis in bizarre surgical circumstances and manage patients with rare complications swiftly and precisely to prevent permanent future disabilities.

Keywords: Young male; Intermittent abdominal pain; Intussusception; Non-obstructive.

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INTRODUCTION

Lipomas are benign proliferation of adipocytes and can arise from any part of the body.[1] Here, a lipoma arising from the ileumcausing non-obstructive intussusception in a young male patient is being reported. Intussusception in adults is usually rare and is seen in less than 1 per 1300 abdominal surgeries. Though 95% of intussusception are seen in children and are usually idiopathic, a cause is generally present in adult cases (90%).[2]

Clinical Description:

A 45-year-old gentleman presented to our outpatient department with complaints of lower abdominal pain for 4 to 5 years and aggravated for 15 days. There was no history of radiation of the pain, and it was not associated with nausea and vomiting, constipation, or abdominal distention. His general condition was fair, with no significant weight loss. The head-to-toe examination was insignificant. His vitals were stable andon examination, the abdomen was soft and non-tender. There was no local rise of temperature nor was any mass palpable. On performing a rectal examination, the walls of the rectum collapsed with normal sphincter tone.

As the clinical examination was insignificant, and the presentation was uncommon, an ultra sonography of the abdomen and pelvis was done. The report showed ileocolic intussusception with the intussusceptum measuring 10 cm with an incidental horse-kidney. After 24 hours of a conservative approach, acontrast-enhanced computed tomography of the abdomen was doneto confirm the diagnosis and showed a bowel within bowel configuration of size 6.5cm X 3.5cm X 5.5cm, and lipoma measuring 7.1cm X 4.5cm, with an incidental horseshoe kidney (Fig. 1).

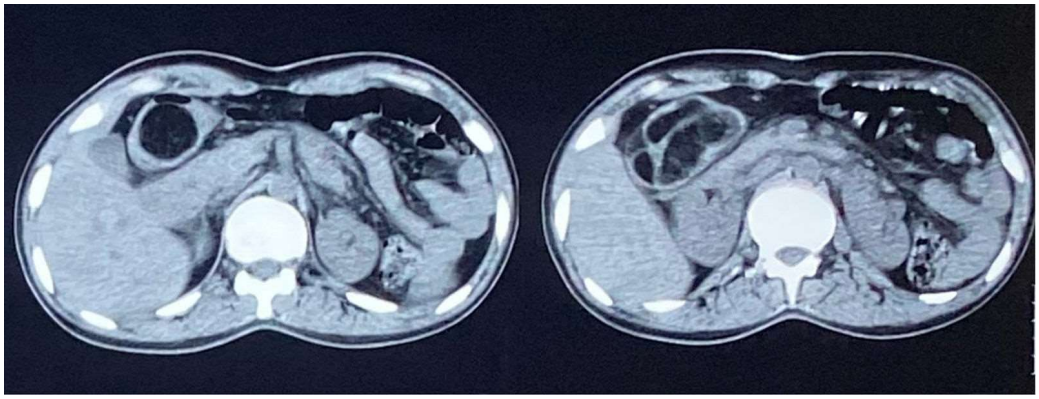

Fig. 1: CECT of abdomen and pelvis

Diagnostic laparoscopy showed intussusception of ileum into caecum without gangrenous changes of the bowel. Due to the difficulty in completely mobilizing the intussuscepted bowel (Video 1), a mid-line laparotomy was taken to manually reduce the bowel. (Fig. 2) A swelling was noted on the terminal ileumapproximately 10 cm from ileo-caecal junction. (Fig. 3) Blunt dissection was done and the extension of the swelling to the mucosa was noted. Hence, the entire tumor along with a part of the bowel was resected out and sent for histopathological examination. (Video 2) The remaining portion of the bowel was examined and revealed multiple other lipomas arising from the mucosa of the bowel which served as a lead point for intussusception. They were soon resected and continuity was maintained using end to end type of bowel anastomosis.

Fig. 2: Reduction of intussusception

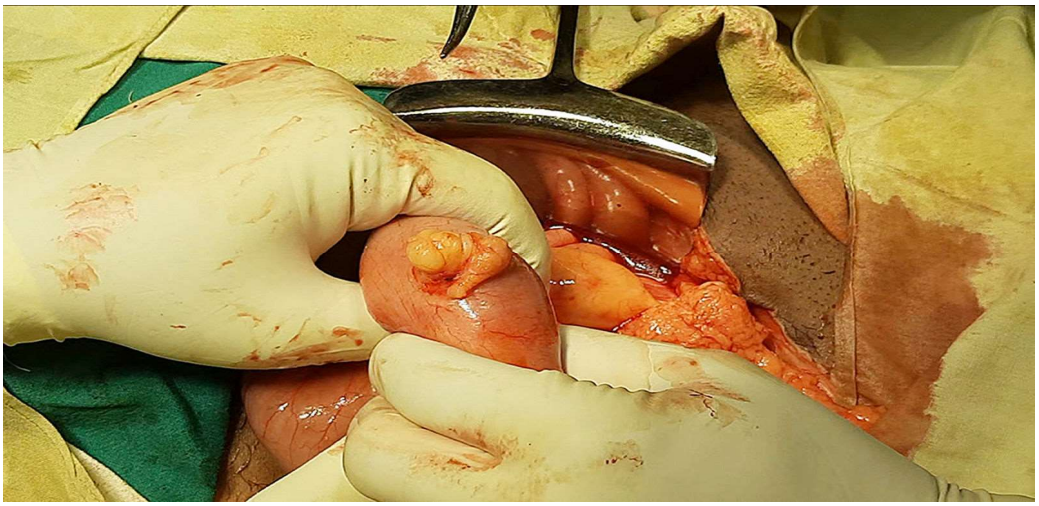

Fig. 3: Ileal Lipoma

The patient with stood the procedure well and was shifted to post anesthesia care unit. The patient started passing flatus on post-op day 4, and stools on post-op day 6. He was discharged on the seventh post-operative day. He was followed up for a month was uneventful.

DISCUSSION

Intussusception is defined as the telescoping of one segment of the bowel into a distal segment. In 1674, Barbette of Amsterdam described the first case of intussusception and was first presented as "introsusception" in 1789 by John Hunter.[3] Intussusception is more commonly seen in children with a child-to-adult ratio of 20:1.[4] In adults, it usually presents as an emergency due to intestinal obstruction. However, in cases without obstruction, the clinical presentation is quite vague and can be challenging.

Interestingly, adult intussusception is usually secondary to a pathologic condition thatserves as a lead point. The causes are most commonly discovered intraoperatively and include polyps, carcinomas, Meckel's diverticulum, colonic diverticulum and other benign neoplasms (like lipomas).[2]

The four types of intestinal intussusception include enteric (jejuno-jejunal and ileo-ileal), Ileocecal, Ileocolic, and Colocolic.[5] The most common symptoms include abdominal pain (89%), nausea, vomiting, weight loss, diarrhoea, constipation and malena (29%).

Lipomastypically present as solitary, painless, subcutaneous, mobile nodules over the neck and trunk. Intestinal lipomas comprise about 21.4% of all small bowel tumours (0.6% to 2% of all GI tumours). They are usually small and single, but present as multiple in 10% to 15% of the patients. They usually present as recurrent non-specific symptoms like abdominal discomfort, constipation and diarrhoea. Lipomas more than 2 cm are generally symptomatic, and present with abdominal pain with alternating diarrhoea and constipation.[6]

The diagnosis of such lipomas is usually difficult and is most commonly done intraoperatively. However, the most accurate diagnostic tool for intestinal lipomas is an abdominal CT. Endoscopy could be performed for polypoidal subepithelial lipomas with simultaneous biopsy.[7]

Treatment of intestinal lipomas is dependenton the clinical presentation. The presence of complications would warrant an excision, but in asymptomatic cases, a conservative approach is preferred. Traditionally, the excision is done using open abdominal surgeries but, endoscopic approaches are increasingly becoming popular for lipomas less than 5 cm. In cases of large lipomas, as presented in our patient, an open approach is generally preferred.[8]

CONCLUSION

Non-obstructive intussusception should be kept as a differential for patients presenting with intermittent abdominal pain of long duration. Young aspiring surgeons should bear in mind that while diagnosing rare cases may make them seldom correct, there is a chance that they are accurate this time.

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