1130-0108/2013/105/8/501-502
Revista Española de Enfermedades Digestivas

Rev Esp Enferm Dig (Madrid
Vol. 105, N.º 8, pp. 501-502, 2013

# Letters to the Editor

## Spontaneous expulsion of a large left-colon lipoma

*Key words: Colonic lipoma. Intestinal subocclusion. Expulsion.*

*Dear Editor,*

We report herein a very uncommon case of spontaneous expulsion of a large colonic lipoma from the rectum without causing intestinal perforation.

### Case report

We report the case of a 45-year-old patient with an unremarkable history who 15 days before his current admission had visited the Emergency Room because of abdominal pain and diarrhea, where he was diagnosed with acute gastroenteritis and managed with an antibiotic. He returned to the hospital because of persistent abdominal pain and pseudo-diarrhea. The abdominal examination was consistent with intestinal subocclusion of the mechanical type. Blood testing revealed mild leukocytosis and elevated CRP levels. Microbiological stool examinations yielded negative results. An abdominal CT scan showed a large endoluminal lesion, around 3.5 x 9 cm in size, at the sigma-descending colon level; the lesion was morphologically smooth and radiolucid, which was highly suggestive of a fatty tumor.

The clinical-radiographic correlation allowed to reach a diagnosis of left-colon subocclusion secondary to fatty tumor. Surgery was decided upon within 24-48 h in view of clinical stability. At 24 h the patient presented with worsening abdominal pain followed by the spontaneous expulsion of a mass from the rectum. The mass was kidney-like in shape and was collected for histopathologic exams.

The expelled mass (Fig. 1) had a smooth surface, was light brown in color, and measured 70 x 50 x 45 mm.

Following tumor expulsion the patient remained totally asymptomatic; a new CT scan was performed, which revealed no tumor and no signs of perforation.

The patient was discharged from hospital after 48 h having spared himself a laparotomy procedure.

The histopathologic exam confirmed the diagnosis of submucosal lipoma.

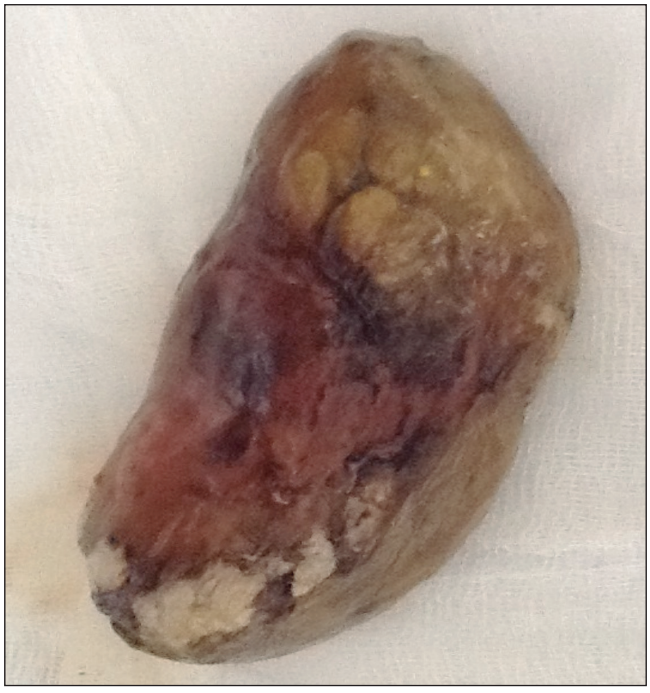

Fig.1.

## Discussion

Colonic lipomas are benign tumors most often located in the right colon. They are usually small (< 2 cm) and asymptomatic, and often represent an incidental finding during colonoscopy.

Large lipomas may give rise to symptoms in 30 % of cases and manifestations are highly variable, from intermittent abdominal pain to intestinal obstruction, invagination, and lower digestive bleeding. Its therapeutical approach varies according to tumor size and clinical manifestations. Thus, a small bleeding lipoma may benefit from polypectomy, whereas a large lipoma with intestinal occlusion signs should undergo surgical resection.

Only rarely do lipomas separate from their base and become expelled via the rectum; even more rarely is secondary intestinal perforation averted in such cases. The exact mechanism of lipoma self-amputation is not clearly understood. In pedunculated lipomas the pedicle may become strangled and then undergo necrosis, which would bring about their detachment. Another mechanism may be ulceration of the mucosa covering the lipoma, which would then drop into the colonic lumen.

This case was unusual both from the clinical presentation viewpoint –colonic subocclusion by a large lipoma in the left colon– and regarding its outcome –spontaneous expulsion without secondary intestinal perforation; both factors allowed laparotomy to be avoided for our patient.

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