LIPOMA OF ILEUM CAUSING INTUSSUSCEPTION

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The tumours of the small intestine constitute about 5% of all tumours of the gastrointestinal tract[1]. These tumours are about equally divided between benign and malignant varieties[1,2]. The autopsy incidence of small intestine tumours is about 0.2%[3]. Lipoma of the small intestine is very rare and such tumour causing intussusception is also rare[4]. We present a case of lipoma of the ileum causing intussusception.

CASE REPORT

A fifty-one year old female was admitted on 25th of November in 1989 at Ankara Numune Hospital with complaints of abdominal pain since three months. She felt a mass in the abdomen and defecation occurred once every two or three days. On examination the patient was well. The temperature was 36.7°C, pulse 80/min, and the blood pressure 90/50mm of mercury. There was a slight distension of the abdomen and the peristalsis was a little bit loud. A mobile mass was palpable in epigastrium. Perrectal examination revealed nothing significant. Laboratory examination showed the following: Haemoglobin was 11.2g% and WBC count 3700 per cubic mm. Serum electrolytes levels and liver function tests were normal. Fasting blood sugar 75mg% and serum creatinine 0.9mg%. Urine examination showed 12-14 leukocyte and 5-6 epithelial cells per high power field. Barium contrast colonography showed a mass in the transverse colon (Figure 1),

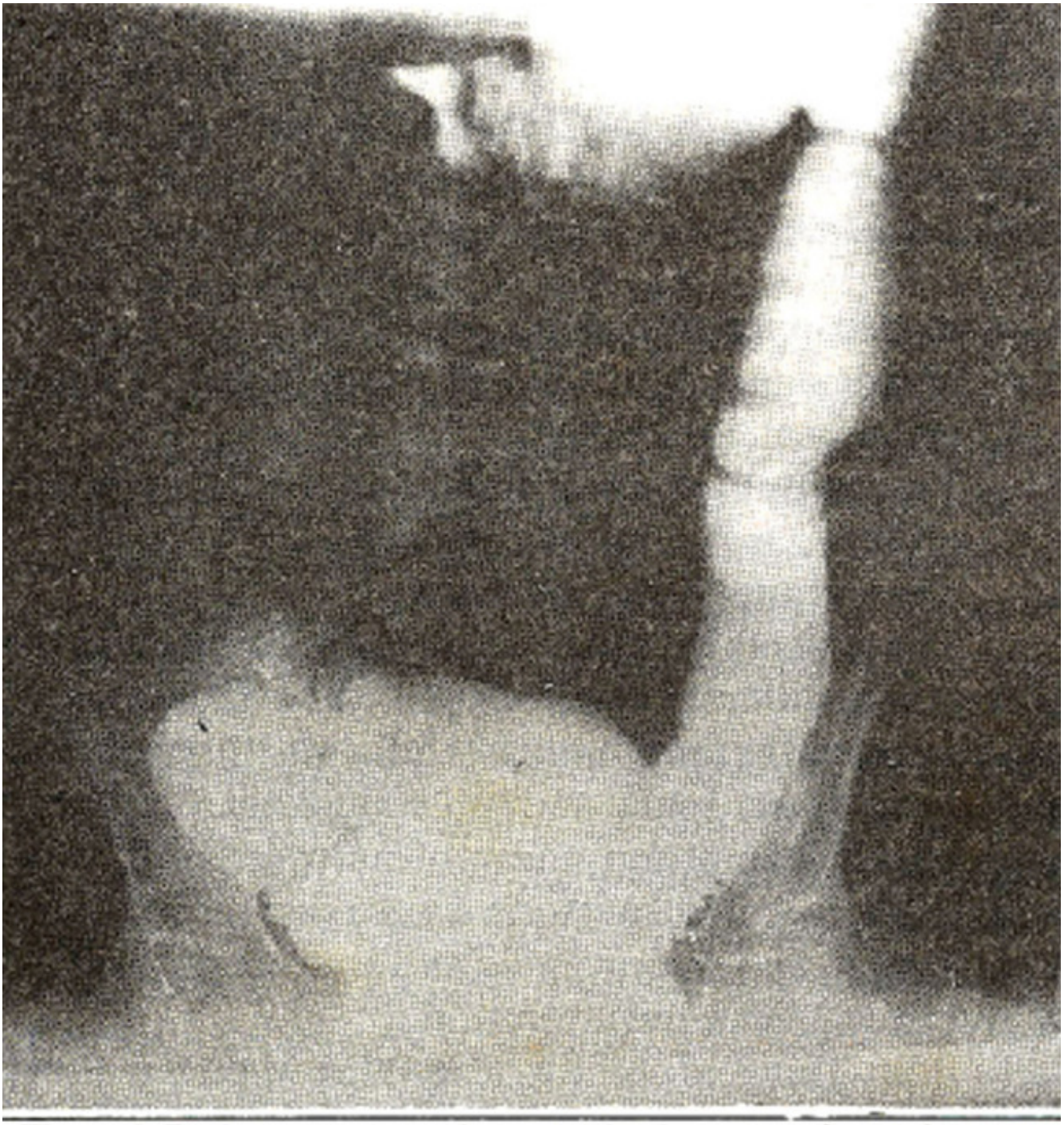

Figure 1. Barium contrast colono graphy demonstrating an intussusception in the transverse colon.

and abdominal ultrasonography revealed a 49mm, diameter mass, very mobile from epigastrium to the pubis. Provisionally, the case was diagnosed as colonic malignancy. On exploratory laparotomy, a mass, 10 cm proximal to the ileocaecal valve was detected which was causing ileocolic intussusception. The serosa was irregular and there were some firm lymphnodes in the mesentary of ileum and ascending colon. Thinking that the pathology could be malignant, right hemicolectomy and end-to-end ileotransverse colic anastomosis was carried out. The patient was discharged on the seventh postoperative day. The resected specimen was reported “submucous lipoma” pathologically (Figure 2).

Figure 2. Photomicrograph of submucous lipoma.

DISCUSSION

Lipomas are the third commonest benign tumours of the small intestine after adenomas and

leiomyomas. Gastro-intestinal lipomas are mostly solitary, their frequency varies in defferent series. They are mostly found in colon[3] ,but terminal ileum is also a common site for benign tumours of small intestine. Most of benign small jntestinal tumours cause no symptoms. Sixty percent of these are first recognised when they have led to intestinal obstruction due to an intussusception as in our case. Machella reported obstruction and bleeding as the symptoms of benign tumours of ileum[5]. The lipomas may be intra and extra luminal. In txaluminal types cause an intussusception. In adults, at least 85% of intussusceptions are the result of an intraluminal lesion. Intussusception in adults is frequently intermittent and presents itself as acute precipitous, cramping and abdominal pain. Because of difficulty in diagnosis of small intestine tumours, they should be resected when discovered since operative mortality is small and prognosis is excellent when tumour is recognised before it causes obstruction. But post resection• complication such as obstruction or bleeding carries a mortality of 20%. Good prognosis in our patient was because she had come to the hospital before the development of gangrene.

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