Spontaneous expulsion per rectum of an ileal lipoma


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Summary: We report a case of spontaneous expulsion of a lipoma in a 32 year old male patient who presented with recurrent attacks of subacute intestinal obstruction. During one such episode the patient developed unusually severe abdominal pain and expelled a fleshy mass per rectum which, on histopathology, was found to be a lipoma attached to a necrosed portion of the small intestine. The pain disappeared immediately; a subsequent barium meal examination revealed normal appearances and the patient has remained completely symptom free 10 months after the incident.

Introduction

Intussusception of the bowel, although common in children, is rare in adults and because of the non-specific nature of the symptoms, the diagnosis is invariably delayed. Spontaneous expulsion of lipoma per rectum is an extremely rare phenomenon. Only a few cases have been recorded and we report one such case where spontaneous expulsion of a small bowel lipoma resulted in complete relief of symptoms.

Case report

A 32 year old male was admitted with the complaint of colicky abdominal pain occurring off and on for 8 months. The pain was accompanied with a feeling of a moving ball of wind in the central part of the abdomen. On occasions the patient was able to feel a mass and could even move it around. There was no history of vomiting, loose motions, abdominal distension, cessation of flatus or faeces, fever, loss of appetite or weight, night sweats, cough, haematemesis or melaena. The abdominal examination revealed a vague mass 8 cm × 5 cm, oval in shape, which changed its position between examinations. The bowel sounds were slightly increased. Rectal examination did not reveal any abnormality. During his stay of 14 days in the hospital he developed 3 episodes of subacute intestinal obstruction and each time a plain film of the abdomen showed evidence of distal small bowel obstruction with multiple air fluid levels. All these episodes were treated with conservative measures of nil by mouth, intravenous fluids and Ryle's tube suction. A barium meal follow-through examination revealed the caecum to be pulled up and distorted. A diagnosis of ileocaecal tuberculosis was made and the patient was started on specific treatment. About 4 weeks after his discharge from the hospital he again developed severe colicky abdominal pain which lasted for 7 days and for the first time was associated with bilious vomiting and mild abdominal distension. On the 7th day the pain became very severe and the patient passed a fleshy oval mass along with a small quantity of fresh blood per rectum. Histological examination showed that the tumour was a lipoma and contained an area of necrosed small intestine. The pain disappeared soon after the passage of the lipoma and the patient remains asymptomatic 10 months after the incident. A repeat barium meal follow-through examination was normal.

Discussion

Intussusception is the invagination of a part of the intestinal tract into another. It is a common cause of intestinal obstruction in children; the greatest frequency (69%) is in the first year of life and adults constitute only 5% of all cases of intussusception. In children the disease is of a short duration and most patients present with acute intestinal obstruction, while in adults intussusception runs a sub-acute or chronic course and the average duration of symptoms is 8 months. Another difference between the two forms of intussusception is the aetiology. In children most cases are idiopathic while in adults an organic cause can

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be identified in about 80% of patients. In the West, benign or malignant tumours account for about 65% of all cases of intussusception and inflammatory disorders such as tuberculosis are rare. By contrast, in developing countries like India tuberculosis as a cause of intussusception is much more common; according to one study 14% had intestinal tuberculosis while another study found granulomas in as many as 37% of cases. An understanding of the aetiology of intussusception is important since neoplastic lesions call for surgery and resection of the involved bowel while inflammatory lesions such as tuberculosis can be safely managed by medical treatment.

In the present case the intussusception was ileocaecal and the cause was a large lipoma. The radiological appearances were misinterpreted as ileocaecal tuberculosis but on review the findings are typical of intussusception. Spontaneous expulsion of the tumour was perhaps due to ischaemic necrosis resulting in the sloughing off of the lipoma along with a part of the bowel wall. According to a recent review by Zamboni et al. a total of 25 similar cases have been reported to date. Most of these patients had a lipoma in the colon (72%) followed by the small bowel (24%) while in the remaining 4% the source was unknown.

After the spontaneous expulsion of the tumour, the patient should be reassessed by colonoscopy or radiological examination to exclude the possibility of either multiple polyps or the presence of a remnant of the original tumour.

References

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