External resection of a giant sigmoid lipoma causing colonic intussusception and prolapse through the anal canal

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ABSTRACT

We depict the case of an 80-year-old female patient who presented to us with a history of protruding mass per anum. Sigmoidoscopy revealed a large globular pedunculated polyp at 22 cm from the anal verge resulting in a sigmoidorectal intussusception. Endoscopic polypectomy was not technically possible due to the large size of the polyp. At the time of prolapse the polyp was tied at its pedicle with thread and resected surgically. The patient is asymptomatic on follow-up.

Key words: Sigmoid lipoma, colonic intussusception.

INTRODUCTION

Colonic lipomas are rare benign asymptomatic submucosal tumours. But large lipomas may turn symptomatic and lead to various complications. Segmental colonic resection is the treatment of choice for giant symptomatic lipomas. Endoscopic removal of giant lipomas has also been reported.[1] Reports of external resection of giant sigmoid lipomas are very few in the literature.

CASE REPORT

An 80-year-old female presented to us with a two-month history of recurrent episodes of mass protruding through the anal canal. The mass was reducible. There was no history of bleeding per rectum, constipation, prolonged straining, digital evacuation or weight loss. There was no history of significant illness in the past. Clinical examination was unremarkable. A globular firm mass was felt in the rectum and the finger could be moved all around the mass.

Investigations: A routine blood test and renal and liver function tests were normal. Flexible sigmoidoscopy demonstrated a very large globular mass in the rectum and after pushing the mass up with the tip of the scope, further inspection proximally showed the attachment of the pedicle at 22 cm from anal verge. The mucosa over the swelling appeared normal. A full-length colonoscopy was normal except for the large sigmoid polyp. The biopsy showed normal colonic mucosa. Ultrasound of the abdomen was normal. CT scan showed an intraluminal lesion in the sigmoid colon with fat density.

Endoscopic polypectomy was attempted but was not successful due to the large size of the polyp and its location. The patient did not consent to undergo a laparotomy. Instead a procedure whereby the polyp was tied with thread at its pedicle the next time it prolapsed was undertaken. (Figure 1) An attempt was made to cut the pedicle within sutures using an endoscopic polypectomy snare. But because of the presence of thick tissue at the pedicle, cautery was ineffective. Hence surgical resection was carried out externally under spinal anaesthesia. The resected specimen was 7 cm long. Histopathology of the tissue revealed a lipoma (Figure 2). The patient's recovery was uneventful and she was asymptomatic on follow-up.

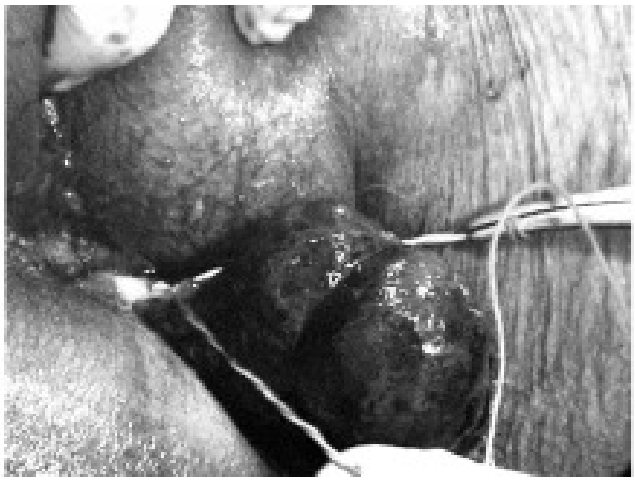

Fig. 1: Giant polyp tied at its pedicle with a thread when it prolapsed out of anal canal.

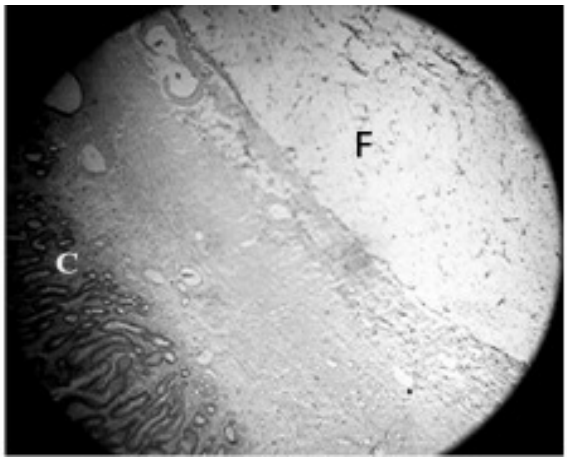

Fig. 2: Photomicrograph of resected specimen showing colonic mucosa overlying the fatty tissue which is consistent with lipoma .C- colonic mucosa, F- fatty tissue (H&E stain, magnification X 40)

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DISCUSSION

Lipomas account for 4% of benign gastrointestinal tumours and 90% of lipomas are submucosal.[2] The commonest site for symptomatic solitary large bowel lipoma is the ascending colon, including the caecum, followed by the transverse colon, descending colon, sigmoid colon and rectum.[3] The peak incidence for lipoma large bowel is in the fifth and sixth decades.[3] Small lipomas are usually asymptomatic, but large lipomas can present with bleeding, abdominal pain and change in bowel habit.[4] Rarely, complications like rectal prolapse and intussusception may also occur.[5,6] The naked fat sign following biopsy, and elasticity of the lesion are typical features encountered during colonoscopy.[2] Barium enema of these lesions shows features like intact mucosa, sharp margination and obtuse angles between the lesion and the adjacent colonic wall, as well as features characteristic of lipomas like pliability and shape change, broad pedicles and spherical appearances en face.[7] The high fat content of these lesions is easily discernible on CT and MRI.[8]

Giant sigmoid colon lipomas can rarely present with intussusception and prolapse through the anal canal.[5] Our patient also had a giant sigmoid lipoma causing intussusception and prolapse through the anal canal. The usual treatment for giant lipomas is segmental colonic resection. But, lipomas less than 2.5 cm in size or of the pedunculated type can be removed endoscopically.[9] Endoscopic resection is risky in giant lipomas because of the high likelihood of bleeding and perforation. There are case reports of endoscopic polypectomy of giant lipomas using electro surgery with snare[1,10] and endoloop[11]. There are case reports of laparoscopic assisted resection of giant sigmoid lipoma under colonoscopic guidance.[12] Araki et al have reported endoscopic removal of a large lipoma followed by clipping of the mucosa.[13] There is a single case report of transanal resection of a large colonic lipoma with anal canal prolapse.[14] To the best of our knowledge, this is the second report of external resection of giant sigmoid lipoma prolapsed though the anal canal.

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