Case report

Small Bowel Obstruction Secondary to Small Bowel Lipoma: A Case Report & Literature Review

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ABSTRACT

Small bowel obstruction is a common acute presentation in any general surgical unit, however an obstruction secondary to a intusussuception from a complication of Small Bowel Lipoma are rare. I present a case of small bowel obstruction caused by Small bowel lipoma which was successfully treated with a laparotomy and Small Bowel Resection with Primary Anastomosis

1. INTRODUCTION

Intestinal Lipoma are rare benign non epithelial tumors, usually slow growing. Most colonic lipomas were detected incidentally during surgery or endoscopy with incidence ranges from 0.035% to 4.4%. The majority Intestinal Lipoma are small and asymptomatic. Larger lesions may be symptomatic & causes several complications such as Intussusception, Superficial Ulcerations & bleeding.

2. CASE REPORTS

A 51 years old gentleman with no known co-morbids came to Emergency Department with complaints of bowel obstruction symptoms for the past one week. Clinically upon examination abdomen was Soft but distended and bowel sound is active. Plain abdominal radiography showed dilated small bowel (stack coin appearance) but CT abdomen reported as Abscess collection at the ileocecal junction suggestive of a ruptured appendix with small bowel obstruction. Proceeded with Laparotomy on the same day, intra-operatively noted intussusception of small bowel 45 cm from ileocecal valve and multiple small lipomatosis mass along small bowel. Proximal Small Bowel to Intussusception was dilated while distally collapsed, hence the decision for Resection of Small Bowel with primary anastomosis. Patient was discharged well on Day 10 of Surgery.

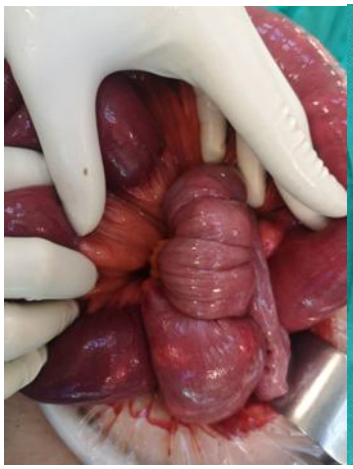

Figure 1 intraop finding

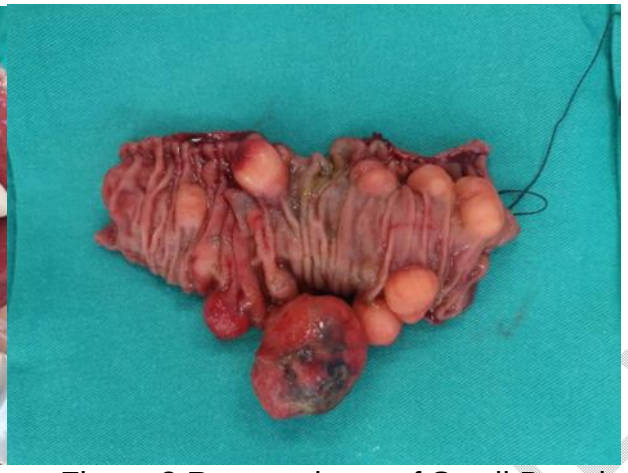

Figure 2 Resected part of Small Bowel

3. RESULTS AND DISCUSSION

Small Bowel Obstruction is a common Acute Emergency in hospital setting. Small Obstruction secondary to Intususception from a lipoma is a rare occurance. Adult intussusceptions are found less than 1 in 1300 abdominal operations.

Most Intestinal Lipoma are asymptomatic but larger intestinal lipoma more than 2 cm can cause complications such as massive haemorrhage, obstruction, perforation, intussusception, or prolapse.

In practise it is difficult to diagnose an Intestinal lipoma and differentiate it from malignancy. Several investigations proven to be helpful such as Barium Enema, CT scans and Colonoscope.

In Barium Enema the lipoma can presented as the squeeze sign where it changes in size and shape during peristalsis. CT can diagnose Intestinal Lipoma with relative certainty due to its uniform appearance and density and the negative Hounsfield unit (HU: –50). During Colonoscope features include the “tenting” sign, where the mucosa tents over the lesion when grasped with forceps, the “cushion” sign, where flattening of the lesion is followed by restoration of its shape on pressure being removed, and the “naked fat” sign, where adipose tissue discharges from the mucosal defect following biopsy.

The management for Intestinal Lipoma are mostly surgical resection especially if its symptomatic and presenting with complications like haemorrhage, Intestinal Obstruction or perforation.

CONSENT (WHEREEVER APPLICABLE)

patients' written consent has been collected and preserved by the authors

ETHICAL APPROVAL

IT IS NOT APPLICABLE

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