

Intussuscepted Sigmoid Colonic Lipoma Mimicking Carcinoma Rectum

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Abstract

Adult colorectal intussusception is a relatively rare condition. It is different from that of a child in that, most cases have an organic etiology like a malignant or benign neoplasm. This is a 40 year female patient presenting with passage of blood and mucous per rectum later diagnosed as sigmoidorectal intussusception due to submucous lipoma in sigmoid colon

that was protruding through anus giving the appearance of a large polypoid rectal growth.

Key words: Carcinoma rectum, Colonic lipoma, Intussusception.

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Introduction

Intussusception may be described as telescoping of a segment of bowel into its adjacent one. It is a relatively uncommon cause of intestinal obstruction in adult (less than 1%).¹ Of all intussusception cases only 6%² occur in adult and most of them are in the right colon. Unlike pediatric cases 80%³ of adult intussusception has a pathologic lead point. Adenomatous polyp, adenocarcinoma, lymphoma, leiomyosarcoma, and rarely lipoma are responsible^{4,5} in colocolic intussusception. Colonic lipoma as a lead point of intussusception is uncommon, and twice as frequent in women than in men.⁶ We present a female patient with a large lipoma in sigmoid colon causing colorectal intussusception and growth protruding through rectum.

Case Report

A lady of 40 years presented with passage of blood and mucous per rectum for 7 days, and sense of incomplete bowel evacuation for 3 months. When she presented to us, on inspection of perianal region, anus was patulous with blood and mucus soiling in the perianal region. Bloody discharge was so much that she had to wear a sanitary napkin.



Fig-1: Large growth protruding through rectum.

Digital rectal examination revealed a large pedunculated mass in the rectum. Its upper limit could not be reached. She was immediately sent for a per-rectal biopsy and was advised to report with the histopathology report on OPD in 3 days.

But on that night the mass bulged out through the anus and patient was unable to bear the pain so she got admitted from the surgical emergency. Manual reposition of the lump was done. Patient was given inj. pathedine for pain and local magnesium sulphate (MgSO₄) compression was given to reduce the perianal edema.

She was mildly anaemic and anxious but otherwise normal. Her vitals were stable. Her abdomen was not distended, slightly tender on palpation. There was no palpable lump in the abdomen. Bowel sound was sluggish. Other systemic examination showed no

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abnormality. So, our provisional diagnosis was prolapsed rectal growth, probably malignant.

Histopathology report from per rectal punch biopsy taken previously showed - *coagulative necrosis of tissue, few entrapped polymorphs and lymphocytes are seen. No viable rectal mucosal tissue is seen. Repeat biopsy is recommended.*

Colonoscopy and biopsy was advised to exclude any synchronous growth proximally. Colonoscopy report revealed: distorted rectum and colonoscope could not be passed beyond the prolapsed growth. Ultrasonogram of whole abdomen revealed: *gross thickening of wall of sigmoid colon and rectum.* Serum CEA level revealed: 2.8 ng/ml. (not raised). Haematological and biochemical parameter were within normal limit. CXR- NAD. ECG- within normal limit, echocardiogram- LVEF-64%. No wall motion abnormality.

We had to proceed with a working diagnosis of *growth in the rectum (probably malignant)*. We arranged surgery on 24 June 2013 with the plan of anterior resection (APR). Patient and her husband were counseled accordingly.



Fig.- 2: *Intussuscepted sigmoid colon bulging through anus after muscle relaxation under GA.*



Fig.-3: *Invagination of finger through intussusceptum & intussusciens in an attempt to reduce intussusception.*



Fig.-4: *Resected portion of sigmoid colon with pedunculated lipomatous polyp.*

Operation Note

Abdomen was opened by lower midline incision. The whole descending colon and transverse colon was loaded with hard stool. There was a colorectal intussusception and sigmoid colon was pushed along with a large polypoid growth in it through rectum and anal canal, appearing as a prolapsed rectal growth. Then we attempted to reduce the intussusception by simultaneous gentle pushing of the sigmoid intussusciens with the polyp per-rectally and invagination of the the index finger between the intussusceptum and intussusciens per abdominally with gentle milking. At one stage intussusception couldn't be reduced further as the portion of the sigmoid colon was edematous, inflamed and fragile. So, we did the Hartman's procedure and specimen was sent for histopathology.

Histopathology

Sub mucous polypoid lipoma arising from colonic wall. Overlying mucosa is necrotic. Wall of resected portion of colon is congested. No granuloma or malignancy seen.

Her post operative period was uneventful. Colostomy started working in 2 days. We discharged her on 10th POD with the advice of readmission after 6 weeks for Hartman reversal. After 6 weeks restoration of bowel continuity was done and she is now doing fine in 6 months follow up.

Discussion

Colonic lipoma are rare with a reported autopsy incidence of 0.2%.⁷ They are commonly located at the right colon (90%) in particular the caecum.⁸ Majority occurs

in elderly and usually does not produce symptoms unless they exceed 20mm in diameter.⁹ Colonic lipomas can be sub-mucous, intramural, or sub serosal. In our case it was a giant submucous pedunculated lipomamea suring about 5cm x 5cm x 5cm.

Sub mucous pedunculated lipomas can produce symptoms like per rectal bleeding, abdominal pain and vomiting due to intestinal obstruction and intussusception.¹⁰

Preoperative diagnosis of adult intussusception can be done with a high level of clinical suspicion, presence of a sausage shaped mass per abdominally in some cases. USG can rarely diagnose a lipoma in the colon causing intussusception. CT Scan shows typical features of donut/bulls eye/ target sign¹ on cross section of intussuscepted portion of gut if carefully looked for. Barium studies can demonstrate classic “coil spring” sign at the point of intussusception.¹ Colonoscopy on the other hand has been reported to be useful for both diagnosis and treatment of such cases in the form of reduction of intussusception and snaring of the polyp. But there is a significant risk of perforation, and in all cases consent of laparotomy should be taken prior to procedure.

In spite of all investigations many cases are diagnosed at laparotomy because they present as an emergency in the form of intestinal obstruction. Most reported cases of sigmoido-recto-anal intussusception in the literature are caused by adenoma or carcinoma.¹¹ In our case it was a giant submucous lipoma. But unfortunately though the growth was very reachable, a pre-operative histopathological diagnosis could not be made because the mucosa over the growth was necrosed. So, we had to keep malignant growth in our provisional diagnosis and plan our surgery accordingly. In our case the lowest intussuscepted segment was located in the lower rectum without protrusion through the anus initially. Later it did protrude through anus, and laparotomy was done after patient counselling.

Pedunculated lipoma in left colon is a rare entity. So far 254¹² cases reported in literature. Incidence of

submucous colonic lipoma is approximately 0.26%,¹³ which is again very rare. Preoperative differentiation between benign and malignant growth will be helpful to limit the extent of surgery, and avoid hemicolectomy or permanent colostomy.

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