Ileocolic intussusception of ileal lipoma as a cause of lower gastrointestinal bleeding☆

Intususcepción íleo-cólica de lipoma ileal como causa de hemorragia digestiva baja

Here we report the case of a 54-year-old man, with no history of interest, who was admitted to hospital for lower gastrointestinal bleeding, manifested as rectal bleeding with dark blood, which did not affect his hemodynamic stability. In the days before admission, he had abdominal pain with cramps, nausea and vomiting. Because of the characteristics of the feces, a gastroscopy was performed, which showed no abnormalities. When performing a colonoscopy, traces of blood were found throughout the colon, as well as a bulging ileocecal valve. An ileoscopy was performed with some difficulty, without being able to see any damage; but when the endoscope was removed again, a whitish lesion was seen in the base of the caecum, which appeared to be ulcerated, but with no active bleeding, and was about 3 cm and prolapsed through the ileocecal valve (Fig. 1). Biopsies were taken of the lesion, and it was compatible with a lipoma. The study was completed with a CT scan (Fig. 2), which showed a fat and pedunculated mass, originating on the inner lip of the ileocecal valve, that was prolapsed in the base of the caecum. The patient was assessed in the general surgery department, and it was decided to treat the lesion by using elective laparoscopic right hemicolectomy, which confirmed the origin of the lesion. The surgical specimen measured a total of 18×5 cm, with a pedicled lesion originating in the terminal ileum and with a maximum size of 5×2.3 cm, and was brown-colored with macroscopic involvement of the mucosa, compatible with lipoma.

Lipomas are benign, and usually submucosal, mesenchymal tumors. Gastrointestinal lipomas are located primarily in the right colon, and to a lesser extent, in the small intestine.[1] They are usually asymptomatic, and when they do cause symptoms, they are non-specific ones, such as occlusive problems, bleeding, abdominal pain, nausea or diarrhea.

Types of intussusception were classified in 1956 as enteric, colocolic, ileocecal and ileocolic,[2] with the most common being enteric intussusception, because it occurs in 43% of patients.[3] Our case involves an ileocolic intussusception, with an ileal lipoma being the main cause. Generally, in submucosal lesions such as lipomas, conventional biopsies are not the best means for an accurate diagnosis. In our case this was not so, because the lipoma affected the mucosa macroscopically, which allowed us to collect adipose tissue with a conventional biopsy, thus facilitating the diagnosis.

Historically the treatment of symptomatic lipomas has been surgical, as in our case, by the use of a laparoscopic right hemicolectomy. In the past few years, cases of single-port laparoscopy have been reported, with fewer complications and a more acceptable esthetic result.[4]

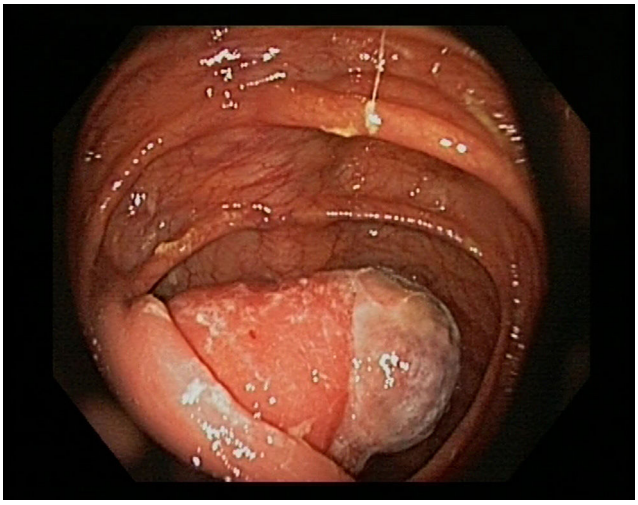

Figure 1 Ileocolic intussusception of ileal lipoma: endoscopic view.

Recently, endoscopic techniques have been developed to treat lipomas in certain cases, mostly in patients who are not candidates for surgery or who reject it.

Endoscopic submucosal dissection is a technique originally intended for superficial neoplastic lesions, but it has also been used to resect symptomatic lipomas.[5] However, this is a complex technique that is not performed at all centers in our setting, and it has a higher rate of complications, mainly perforation and bleeding.

The *loop-and-let-go* technique consists of placing a disposable loop on the lipoma pedicle, which promotes a slow mechanical resection, thereby reducing the risk of bleeding and perforation.[6]

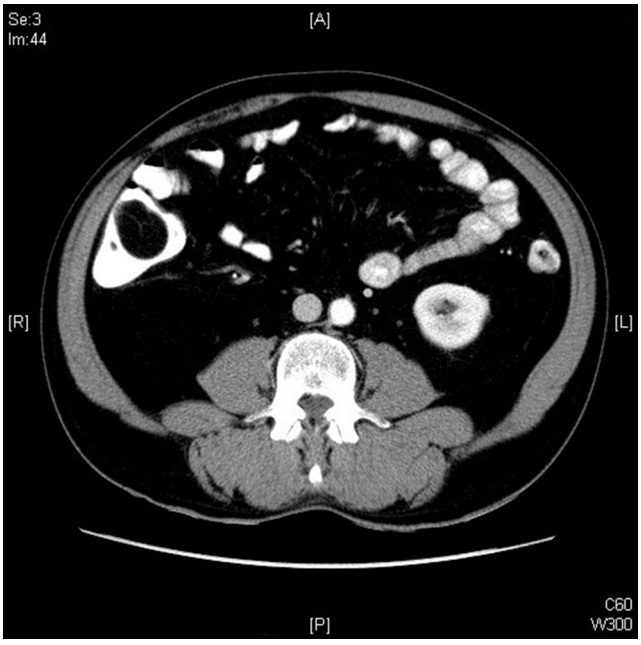

Figure 2 Ileocolic intussusception of ileal lipoma: tomographic image.

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The *unroofing* technique consists of the spontaneous removal of the lipoma from the exposed mucosa after making an incision in the upper half of the mucosal surface of the submucosal mass.[7]

According to the literature, these techniques are mostly used for lipomas located in the colon, whereas in our case the lipoma was located in the terminal ileum, which made the endoscopic approach even more difficult. This being said, cases of ileal lipoma resections have been reported after bringing it into the colonic lumen by aspiration[8] or by placing a cap at the tip of the endoscope.[9]

Despite advances in endoscopic techniques, surgical treatment is of vital importance for sessile lipomas with a wide base of implantation, for cases where diagnosis is uncertain, for lipomas that cause intussusception or obstruction, and for cases of involvement of the serous layers.[10]

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Pancreatic tail schwannoma

Schwannoma de la cola del páncreas

A 75-year-old woman with a history of hypertension, osteoporosis, and cholecystectomy presented with intermittent abdominal pain unrelated to meals and weight loss of 6 kg over the past four months. Physical examination and all laboratory investigations were normal. Upper endoscopy was normal, whereas an abdominal ultrasound revealed a 6-cm, irregular, solid mass in the tail of the pancreas. Computed tomography (CT) scan (Fig. 1A) showed a 7×5 cm diameter, encapsulated, solid heterogeneous tumor, without any cystic component. There were no other intra-abdominal lesions or pathologic lymphadenopathy noted. Magnetic resonance cholangiopancreatography showed normal caliber of the biliary tree and pancreatic duct. CT-guided fine-needle aspiration exhibited cellular spindle cell neoplasm with mild atypia (Fig. 1B). On immunochemistry, the spindle cells were strongly positive for S-100 protein (Fig. 1C) and negative for pan-cytokeratin, CD-34, CD-117, smooth muscle actin and Melan A, consistent with the diagnosis of a pancreatic schwannoma. Distal pancreatectomy with splenectomy was performed and the patient recovered uneventfully, without relapsing disease after a 2-yr follow-up.

Schwannomas (also called neurilemmomas) are encapsulated tumors made entirely of benign neoplastic Schwann cells, which represent the most common peripheral nerve tumors. They grow eccentrically from peripheral nerves or nerve roots with the nerve itself usually incorporated into the capsule. The most frequent locations for schwannomas are lower and upper limbs, head and neck, retroperitoneum, mediastinum, and pelvis.[1] Symptoms and signs are caused by direct nerve invasion, involvement of surrounding tissues, or mass effect. Benign pancreatic schwannoma is a rare entity, with around 50 cases reported in the English literature in 2016.[2] We have only found two previous reports of pancreatic schwannomas in Spain.[3,4] Malignant transformation has been seldom reported in literature. The pancreatic head is the most common location (40%), followed by the body (20%), being tail and uncinate process the least common locations. The most common symptom is abdominal pain and jaundice with proximal tumors, but these lesions can also be found incidentally. As for CT findings, tumors that are predominantly or exclusively composed of Antoni A areas (cellular component) show inhomogeneous, hypodense, solid masses with contrast enhancement, whereas tumors predominantly composed of Antoni B areas (loose myxoid) may exhibit homogeneous cystic masses without significant contrast enhancement.[5] Immunohistochemically, pancreatic schwannomas are positive for S100, Vimentin and CD 56. Conversely, spindle cells in pancreatic schwannomas stain negative for cytokeratin, CD117, desmin, CD34, AE1/AE3, alpha smooth muscle actin, and smooth muscle