

In seven of the ten patients, the VAS score at 72 h was 0. There were no procedure-related complications. The mean hospital stay was 6.9 days (SD 3.67) and a good clinical outcome was obtained in all cases; the patients were discharged without incident.

In recent years, the analgesic efficacy of TAP block has been demonstrated in somatic pain generated in the abdominal wall after different abdominal surgery procedures.

Acute pancreatitis pain has traditionally been classified as visceral in nature. However, we observed the effectiveness of the TAP block in controlling this type of pain in our study. The technique was found to be easily reproducible and safe.

We would like to highlight the almost immediate effect of the analgesia obtained by the TAP block, a differentiating element with respect to any type of therapy with intravenous drugs. The analgesic effect is achieved by the local application of the anaesthetic to the nerve root, which explains its speed. In contrast, in patients treated with intravenous morphine derivatives, the maximum effect is generally achieved after 15–20 min and their effect wanes after 2–3 h, meaning that successive doses have to be administered to maintain optimal levels of analgesia.⁵

As regards the persistence we observed in our patients of low levels of pain, we should probably attribute this to the natural improvement in the acute pancreatitis inflammatory process rather than to the TAP block itself.

This study presents a short case series, with the consequent inherent limitations when assessing the conclusions. Nevertheless, we decided to communicate our results because of the striking nature of the data we obtained. Multicentre randomised studies need to be conducted comparing standard analgesic therapies with TAP block so it can be included as a new therapeutic tool in the treatment of pain in acute pancreatitis.

Funding

The authors have no sources of funding to declare.

Conflicts of interest

None.

References

1. Vargas-Schaffer G. Is the WHO analgesic ladder still valid? Twenty-four years of experience. *Can Fam Physician*. 2010;56:514–7. PMID: 20547511. PMCID: PMC2902929.
2. Smith DI, Hoang K, Gelbard W. Treatment of acute flares of chronic pancreatitis pain with ultrasound guided transversus abdominis plane block: a novel application of a pain management technique in the acute care setting. *Case Rep Emerg Med*. 2014;2014:759508, <http://dx.doi.org/10.1155/2014/759508>.
3. Banks PA, Bollen TL, Dervenis C, Gooszen HG, Johnson CD, Sarr MG, et al. Classification of acute pancreatitis-2012: revision of the Atlanta classification and definitions by international consensus. *Gut*. 2013;62:102–11, <http://dx.doi.org/10.1136/gutjnl-2012-302779>. PMID: 23100216.
4. Tsai HC, Yoshida T, Chuan TY, Yang SF, Chang CC, Yao HY, et al. Transversus abdominis plane block: an updated review of anatomy and techniques. *Biomed Res Int*. 2017;1–12, <http://dx.doi.org/10.1155/2017/8284363>. Article ID 8284363.
5. Valdivielso A. Dolor agudo, analgesia y sedación en el niño (III): Farmacocinética y farmacodinamia de los analgésicos opioides. *An Esp Pediatr*. 1998;48:429–40.

Sergio González Martínez^{a,*}, Helena Gómez Facundo^a, Carmen Deiros García^b, Eva María Pueyo Periz^a, Ruth Ribas Montoliu^a, Daniel Coronado Llanos^a, Josep Masdeu Castellvi^b, Montse Martin-Baranera^c

^a *Departamento de Cirugía, Hospital Moisès Broggi, Consorci Sanitari Integral, Barcelona, Spain*

^b *Departamento de Anestesia, Hospital Moisès Broggi, Consorci Sanitari Integral, Barcelona, Spain*

^c *Departamento de Epidemiología, Hospital Moisès Broggi, Consorci Sanitari Integral, Barcelona, Spain*

* Corresponding author.

E-mail address: sergio4762@yahoo.es

(S. González Martínez).

2444-3824/ © 2020 Elsevier España, S.L.U. All rights reserved.

Giant colon lipoma complicated with intussusception and low digestive hemorrhage[☆]



Lipoma cólico gigante complicado con intususcepción y hemorragia digestiva baja

Intestinal lipomas are the most common benign tumours after adenomatous polyps. They can originate in any segment of the gastrointestinal tract, although they are more

common in the large intestine. The prevalence in the general population is estimated to be in the range of 0.2% to 4.4% and they represent 1.8% of all benign lesions of the colon. They are usually small (less than 2 cm), their size is positively correlated with the presence of symptoms and they can cause potentially serious complications when they become larger than 4 cm (also called *giant lipomas*¹).

We describe the case of a 56-year-old female with a history of obesity, multinodular goiter and fibromyalgia. She went to the Accident and Emergency department complaining of right abdominal pain and haematochezia; she had no changes in bowel habit, weight loss, anorexia or fever. Blood analysis showed mild anaemia (Hb 11.3 g/dl); other parameters were normal. Colonoscopy revealed a pedunculated polypoid lesion about 5 cm in diameter in the hepatic flexure, with no clear glandular pattern and ulcerated areas oozing blood on the surface, causing almost complete stric-

[☆] Please cite this article as: Martín Domínguez V, Moreno-Monteagudo JA, Santander C. Lipoma cólico gigante complicado con intususcepción y hemorragia digestiva baja. *Gastroenterol Hepatol*. 2021;44:126–128.

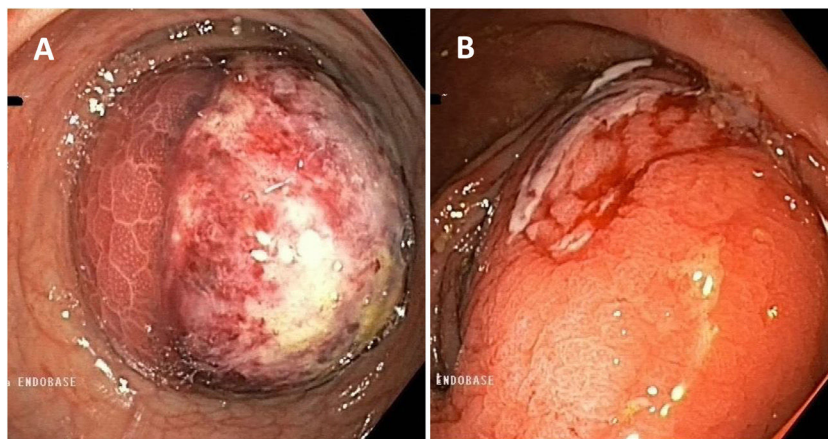


Figure 1 Endoscopic view of lipoma of the colon. A) Ulcerated mass. B) Friable surface with oozing bleeding.

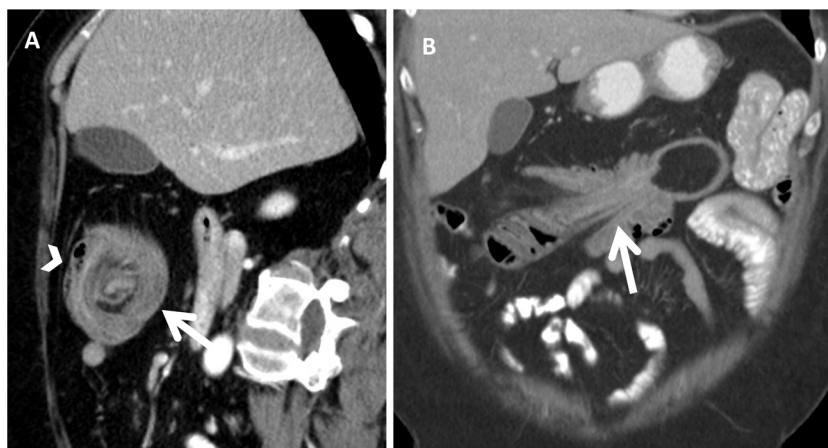


Figure 2 Computed tomography. A) Transverse view of intestinal intussusception; a “target” or “doughnut” image can be seen (arrow) with a lipoma in its centre, as well as mesenteric vessels and fat in the periphery (arrowhead). B) Longitudinal view of the intussusception; the colon can be seen with thickened walls and mesenteric fat and vessels entering the intussusception.

ture of the lumen of the colon (Fig. 1). Despite having active bleeding, management was conservative due to the small amount and diffuse nature. The colonoscopy was completed with no other findings; biopsies were taken from the non-bleeding areas of the lesion, the histology of which revealed focal hyperplastic changes. As malignancy was suspected and the patient had persistent bleeding (even though of small amounts), an abdominal computed tomography (CT) scan was performed, which showed a rounded image with concentric rings of different densities (sagittal sections) and an image of the colon within the colon (in the coronal sections), findings compatible with colocolic intussusception caused by a mass with lipomatous characteristics, without signs of intestinal obstruction or distension of loops (Fig. 2). In view of these findings, we decided to perform an extended right hemicolectomy with ileocolic anastomosis. Pathology examination of the surgical specimen confirmed the diagnosis of a 55 × 43 mm submucosal lipoma, with mucosal ulcerations and erosions. There was no evidence of dysplasia or carcinoma in the surgical specimen, or pathological lymphadenopathy. At the postoperative check-up, the patient was asymptomatic, with normal intestinal transit and no complications.

Lipomas of the colon are slow-growing mesenchymal tumours which originate in the submucosal (90%) or subserosal (10%) layers and mainly affect women in their forties and fifties.^{1,2} The majority of cases are diagnosed incidentally during colonoscopies, when they are identified by their typical yellowish colouring and well defined, smooth borders. Endoscopic diagnosis is reliable in over 60% of cases. The presence of necrosis, superficial ulceration or hardness when taking biopsies can make it difficult to differentiate lipomas from a malignant lesion, so in these cases CT or magnetic resonance imaging is needed. Sometimes, however, in the event of diagnostic uncertainty or complications, segmental resection of the colon is opted for at an early stage, with the diagnosis confirmed after pathology examination of the surgical specimen.¹

Lipomas larger than 4 cm in size, considered as giant lipomas, cause symptoms in 75–100% of cases and complications such as anaemia, intussusception and intestinal obstruction.¹ With regard to bleeding, although rare, there have been reports in the literature of lipomas with ulceration of the mucosa that cause gastrointestinal bleeding.² Taking biopsies in these cases is a debated issue, as it can increase the risk of bleeding and the possibility of

sampling errors means the presence of malignancy cannot be ruled out.

Intestinal intussusception is the introduction of a proximal segment of the intestine into a more distal segment; it represents only 1–5% of intestinal obstructions and can be caused by malignancy (lymphoma, adenocarcinoma) or have a benign cause, such as intraluminal lipomas. The diagnosis of intussusception is confirmed by imaging tests, with CT being the most sensitive and specific (83–100%). The characteristic finding is the presence of colon within colon or ileum within colon, as was found in the case we present here. CT will also show the existence of proximal occlusion and any distension of intestinal loops.^{3,4}

Due to their benign nature, most colon lipomas do not require treatment, except when there is uncertainty about the diagnosis, the patient has symptoms or they are more than 2 cm in size. Endoscopic resection assisted by endoloops or endoclips can be a treatment option in experienced hands. A prior endoscopic ultrasound is advisable to identify the size, borders, vascularisation, layer of origin and extension of the serosa or muscle within the peduncle and to minimise the risk of perforation.^{1,2} Surgical resection is the most widely used treatment for colon lipomas: it is indicated in cases of giant, sessile lipomas, suspected malignancy, serious complications (obstruction, intestinal intussusception, perforation or haemorrhage) or muscle or serous layer involvement (in which endoscopic resection is contraindicated). These days, segmental resections of the colon are most common, using a laparoscopic or open approach, with the rate of complications being low.^{2,5}

We are able to conclude that giant lipomas of the colon are uncommon findings in routine colonoscopies and that the coexistence of two complications in the same patient, in addition to endoscopic characteristics indistinguishable from a neoplastic lesion, is very rare. Therefore, when we detect a giant lipoma, particular attention must be paid to its endoscopic characteristics, using endoscopic

ultrasound to assess its resectability, as the likelihood of future complications is high and they can potentially be serious.

Conflicts of interest

None of the authors have conflicts of interest to declare.

References

1. Crocetti D, Sapienza P, Sterpetti AV, Paliotta A, Gori DE, Pedullà A, et al. Surgery for symptomatic colon lipoma: a systematic review of the literature. *Anticancer Res.* 2014;34:6271–6. Review.
2. Chehade HH, Zbibo RH, Nasreddine W, Abtar HK. Large ileocecal submucosal lipoma presenting as hematochezia, a case report and review of literature. *Int J Surg Rep.* 2015;10:1–4, <http://dx.doi.org/10.1016/j.ijscr.2015.03.007>.
3. Yakan S, Caliskan C, Makay O, Denecli AG, Korkut MA. Intussusception in adults: clinical characteristics, diagnosis and operative strategies. *World J Gastroenterol.* 2009;15:1985–9, <http://dx.doi.org/10.3748/wjg.15.1985>.
4. Cordeiro J, Cordeiro L, Pôssa P, Candido P, Oliveira A. Intestinal intussusception related to colonic pedunculated lipoma: a case report and review of the literature. *Int J Surg Case Rep.* 2019;55:206–9, <http://dx.doi.org/10.1016/j.ijscr.2019.01.042>.
5. Yaman İ, Derici H, Demirpolat G. Giant colon lipoma. *Ulus Cerrahi Derg.* 2013;31:102, <http://dx.doi.org/10.5152/UCD.2013.15.28>.

V. Martín Domínguez*, J.A. Moreno-Monteaquedo, C. Santander

Servicio de Aparato Digestivo e Instituto de Investigación Sanitaria Princesa (IIS-IP), Hospital Universitario de La Princesa, Madrid, Spain

* Corresponding author.

E-mail address: veronicamartin29@yahoo.es

(V. Martín Domínguez).

2444-3824/ © 2020 Elsevier España, S.L.U. All rights reserved.

Abscess secondary to complicated peptic ulcer managed by endoscopic ultrasound-guided drainage with a lumen-apposing metal stent[☆]



Absceso secundario a úlcera péptica complicada resuelto mediante drenaje guiado por ecoendoscopia con prótesis de aposición luminal

We present the case of a 67-year-old female patient with no relevant medical history or history of smoking or alcohol

or substance abuse. She was admitted to Gastroenterology with a six-day history of epigastric pain, for which she had already visited the Accident and Emergency Department five days earlier, but had been discharged home as investigations were normal (lab tests, abdominal ultrasound) and good pain control was achieved with analgesia. On this occasion, analyses showed slight elevation of liver enzymes (AST 64 U/l, ALT 104 U/l, GGT 143 U/l, alkaline phosphatase 187 U/l) and elevation of acute phase reactants (c-reactive protein >350 mg/l, fibrinogen 1000 mg/dl), but abdominal ultrasound was normal once again. During her stay in hospital, good pain control was achieved, the patient's general condition remained good and to complete the tests, an abdominal computed tomography (CT) scan was requested, which she had on day four. The CT scan showed an intra-abdominal collection with a high air-fluid level (12 × 14 cm) in contact with the left lobe of the liver and gastric antrum (Fig. 1A–B).

A gastroscopy was performed to make a differential diagnosis between abscess of biliary or gastroduodenal origin. In addition to an image of extrinsic compression of

[☆] Please cite this article as: Hijos G, Abad D, Laredo V, Alfaro E, Cañamares P, García S, et al. Absceso secundario a úlcera péptica complicada resuelto mediante drenaje guiado por ecoendoscopia con prótesis de aposición luminal. *Gastroenterol Hepatol.* 2021;44:128–130.