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CLINICAL CASE

Pedicled gastric lipoma. Case report☆

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Abstract
Background: The gastrointestinal tract lipomas are a rare, benign, slow-growth condition and can be a diagnostic challenge, they are more frequent in the colon. The gastric lipoma occurs in fewer than 5% of cases, and represents less than 1% of all gastric tumours, usually their finding is incidental and the initial presentation may be obstruction, bleeding and intussusception. The purpose of presenting this case is for its rarity, the few symptoms that the patient presented and to collect the most current information about the diagnosis and treatment.
Clinical case: We report the case of a 59-year-old male patient who after having suffered acute pancreatitis a tomography control was made looking for complications it found a pylorus-duodenal intussusception, an endoscopy was performed and a tumour about 6 cm was found and biopsies without confirm diagnosis, so it was decided to perform a partial gastrectomy, histopathology study confirmed the diagnosis of gastric lipoma as well as disease free margins. He was maintained with adequate postoperative evolution currently asymptomatic.
Conclusions: The gastric lipoma is a rare benign entity that can mimic a malignancy, in our case an incidental finding which was managed by partial gastrectomy with satisfactory postoperative results.

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PALABRAS CLAVE
Neoplasia;
Lipoma;
Tracto gastrointestinal;
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Gastrectomía

Lipoma gástrico pediculado. Reporte de caso

Resumen
Antecedentes: Los lipomas del tracto gastrointestinal son una condición rara, benigna y de crecimiento lento que puede constituir un desafío diagnóstico, son más frecuentes en el colon. El lipoma gástrico se presenta en menos del 5% de los casos y representa menos del 1% de todos los tumores gástricos, por lo general su hallazgo es incidental y su presentación inicial puede ser: obstrucción, hemorragia e invaginación. El objetivo de presentar este caso es por su rareza, los pocos síntomas que presentó el paciente y recopilar la información más actual sobre su diagnóstico y tratamiento.
Caso clínico: Paciente masculino de 59 años para el cual tras haber padecido un cuadro de pancreatitis aguda, se solicitó control tomográfico para buscar complicaciones y se encontró una invaginación píloro-duodenal, se le realiza una endoscopia en la que se identifica un tumor de 6 cm, a pesar de que se toma una biopsia no es posible confirmar un diagnóstico, por lo que se decide realizar una gastrectomía parcial, y el estudio de histopatología confirmó el diagnóstico de lipoma gástrico así como márgenes libres de enfermedad. Se mantuvo con adecuada evolución posquirúrgica y actualmente asintomático después de 18 meses de seguimiento.
Conclusiones: El lipoma gástrico es una entidad benigna rara que puede simular una enfermedad maligna, en nuestro caso, un hallazgo incidental el cual se manejó mediante una gastrectomía parcial con resultados posquirúrgicos satisfactorios.

Background

According to Neto et al.,[1] gastrointestinal lipomas are a rare disease with very few symptoms. They were first described in 1842 by Jean Cruveilhier at the University of Paris. Gastrointestinal lipomas are more frequently found in the colon (60–75%) and small intestine (more than 31.2%)[1]; the gastric lipoma accounts for less than 5% of tumours present in the gastrointestinal tract and less than 1% of benign tumours present in the stomach.[1]

On a global level, there are approximately 220 reports about this pathology.[2] In general, gastric lipomas are slow-growing lesions, and about 90–95% of the cases are submucosal lipomas, while 5–10% constitutes serosal lipomas. The aetiology of the lipoma is still unknown. However, it is believed that it may be an acquired condition or a condition secondary to an embryological modification. Most of these tumours are small and asymptomatic, and are accidently identified while conducting an autopsy.[2] Histologically, these tumours are made up of well-differentiated adipocytes with a fibrous capsule in which yellow tissue may be found if sectioned.[3] Gastric lipomas are more frequently found in the antrum in 75% of the cases. However, they may be found in any part of the stomach.

Gastric lipomas frequently go unnoticed or are confused with other types of more frequent tumours, such as gastrointestinal stromal tumours, leiomyoma, fibroma, neurilenoma, adenomyoma, Brunner gland adenoma and heterotopic pancreas.

The gastric lipoma is a benign entity, but it may simulate a malignant behaviour.[4] When tumours have a size of 3–4 cm, the most frequent clinical symptom is bleeding in the upper digestive tract, which may be acute or chronic and results from the ulceration of the mucosa producing the tumour.[4]

Abdominal pain and obstructive symptoms are common at its onset, and this is more frequent if the tumour has an endoluminal growth that may worsen with intussusception, which is not rare, and may result in lesions located in the prepyloric region and prolapse towards the duodenal bulb.[4] Generally, during an endoscopy, gastric lipomas appear as smooth tumours, oval or round, well-defined lesions, which are compressible and, on conduction of barium studies, present little attenuation.[4]

It has been demonstrated that the tomography is considerably important for the diagnosis of gastric lipomas. In general, these lesions are well circumscribed, uniform, with fatty density and attenuation ranging from −70 to −120 HU. These characteristics allow for a diagnosis by a tomography, without having to conduct an endoscopy or even surgery if the patient presents no symptoms.[5,6]

The surgical treatment may be laparoscopic in tumours smaller than 6 cm, while subtotal gastrectomy is recommended in tumours larger than 6 cm.[7]

Clinical case

A 59-year-old male patient, with a history of marijuana consumption on a single occasion, alcoholism and smoking since he was 28 years old, 8-year progression high blood pressure controlled with enalapril, dyslipidaemia treated with pravastatin and benzafibrate, renal lithiasis with stone expulsion in 2 occasions, the last of which occurred in 2011, and mild acute pancreatitis of alcoholic origin.

The condition began after he was discharged from hospital, to which he had been admitted due to symptoms of acute pancreatitis. He was seen in a gastroenterology outpatient setting and an abdominal tomography was ordered