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## Adult sigmoidorectal intussusception related to colonic lipoma: A rare case report with an atypical presentation



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### ABSTRACT

**INTRODUCTION:** Adult intussusception is rare. Lipoma is the second most common benign tumor of the colon and most common to cause colonic intussusception in adults, but rare.

**PRESENTATION OF CASE:** A 35-years-old male presented with a history of intermittent abdominal pain and bright red rectal bleeding, with symptoms waxing and waning for one month. On physical examination, the abdomen was distended with tenderness over the periumbilical, suprapubic, and left lower quadrant regions with guarding. CT demonstrated colo-colonic intussusception of the sigmoid colon with a 2.3 cm × 2.6 cm intra-mural lipoma of the rectosigmoid region. The patient underwent an exploratory laparotomy with partial reduction of the intussusception, sigmoid colon resection and end colostomy. Histopathology confirmed a 2.5 cm sub-mucosal lipoma without evidence of malignancy.

**DISCUSSION:** Sixty–sixty five percent of cases with intussusception of the large bowel in adults are related to a malignant etiology and most cases of sigmoidorectal intussusception reported in the literature are secondary to underlying malignancy. Colo-colic intussusception is the most common type of intussusception in adults. The incidence of lipomas of the large intestine is reported to range from 0.035% to 4.4%. Ninety percent of colonic lipomas are submucosal and are mostly located in the right hemicolon. Only 25% of patients with colonic lipoma develop symptoms. Colonic lipomas of the rectosigmoid region represent a very rare occurrence and subsequent etiology for sigmoidorectal intussusceptions in adults. **CONCLUSION:** Colonic lipoma should be considered in the differential diagnosis of adults with intussusception, with reduction and resection leading to excellent results.

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## 1. Introduction

Intussusception in adults is rare and accounts for less than 5% of all intussusception cases [1]. Colonic lipoma is rare, and can serve as the lead point for intussusception [2,3]. Adult intussusception cases present with nonspecific signs and symptoms and CT scan is the most sensitive diagnostic modality. We report a sigmoidorectal intussusception in an adult in whom an intramural lipoma was identified as the lead point.

## 2. Presentation of case

A 35-year-old male, with no prior medical or surgical history, presented to the emergency department with a history of progressive abdominal pain and bright red rectal bleeding between and

after bowel movements, with symptoms waxing and waning for one month. On presentation, he experienced severe, constant, sharp non-radiating lower abdominal pain described as 10/10 followed by a single episode of greenish emesis.

On physical examination, the patient was in painful distress. Vital signs were normal. The abdomen was distended with tenderness over the periumbilical, suprapubic, and left lower quadrant regions with guarding. There was no nausea, constipation, diarrhea or rectal pain. Bowel sounds were normal. There were no additional signs to suggest peritonitis or acute intestinal obstruction. Three-view plain abdominal x-rays were performed and did not show signs of obstruction or perforation. CT of the abdomen and pelvis demonstrated colo-colonic intussusception of the sigmoid colon with a 2.3 cm × 2.6 cm intra-mural lipoma of the recto-sigmoid region likely to be the lead point and no signs of large bowel obstruction (Figs. 1–4). In the absence of signs suggestive of acute intestinal obstruction and apparent benign nature of the mass on CT, the patient was admitted for initial lower gastrointestinal endoscopy to confirm the lipoma and exclude malignancy. Re-examination on post-admission day one revealed a soft, mildly distended abdomen without guarding and with normal bowel

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Fig. 1. Axial view showing the proximal part of the colo-colonic intussusception of the sigmoid colon.



Fig. 2. Axial view showing a mass (lipoma) filling the distal sigmoid colon that was the lead point.



Fig. 3. Coronal view.



Fig. 4. Sagittal view showing mass (lipoma) filling the distal sigmoid.

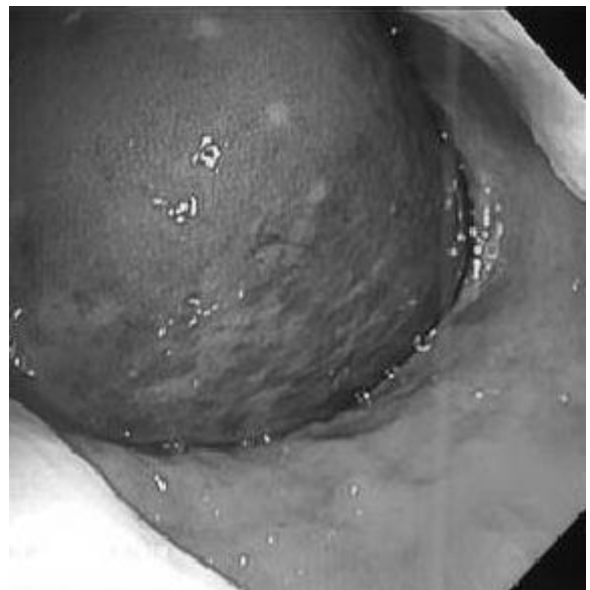


Fig. 5. Colonoscopy showing obstruction/intussusception.

sounds. Vital signs remained within normal. Lower gastrointestinal endoscopy was performed and proctoscopy revealed congested, friable colonic mucosa that completely filled the rectal lumen without evidence of malignancy (Fig. 5). Reduction was not attempted as it did not appear feasible. Exploratory laparotomy was carried and reduction of the intussusception was attempted. Only partial reduction was possible and segmental sigmoidectomy (21 cm) was performed leaving approximately 10 cm of intussusceptum within the intussusceptum. The condition of the bowel was sub-optimal for primary anastomosis. Both bowel segments after resection were inflamed and edematous, thus end colostomy was performed. The

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