

Mesenteric Lipoma: A rare Presentation with acute intestinal Obstruction

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ABSTRACT

Introduction: Lipomas are slow-growing, lobulated, soft, mobile mass, usually found subcutaneously but can be found anywhere in the body.

Case description: Our hospital presented with a case of mesenteric lipoma causing acute intestinal obstruction. Patient had a large tumor on the mesenteric border of ileum which was resected and on histopathology came out to be a mesenteric lipoma.

Discussion: Mesenteric lipoma presenting as acute intestinal obstruction is a rare instance with very few cases being reported so far around the globe.

Conclusion: Though mesenteric lipoma causing intestinal obstruction is rare. But from this case report we conclude that it should be considered as a differential diagnosis when patient presents with acute abdomen or intestinal obstruction.

Keywords: Acute abdomen, Intestinal obstruction, Mesenteric lipoma.

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INTRODUCTION

Lipomas are fatty tumors. These can be single or multiple, soft, rounded or lobulated, mobile, slow-growing, and are usually subcutaneous. They are known to occur especially on the neck, trunk, and extremities but can occur anywhere in the body.¹ Although lipomas are common, mesenteric lipomas are rare. This tumor often does not cause any symptoms but in case the tumor grows very large, it may compress the bowel and present with abdominal pain and can contribute to intestinal obstruction.²

CASE DESCRIPTION

A 30-year-old lady came to our hospital with chief complaints of abdominal pain and distension since 3 days with nonpassage of stools for last 2 days and nonpassage of flatus for 1 day. Patient had no history of similar complaints in the past. The patient's peripheral pulses were not palpable and blood pressure could not be assessed in any limbs. Patient was resuscitated with large volume of intravenous normal saline. Patient had to be taken on vasopressors and shifted to intensive care unit (ICU) for hemodynamic support. After 12 hours, patient had a feeble radial pulse 110/min with blood pressure 94/56, still on vasopressors. X-ray abdomen supine showed dilated small bowel loops. No further radiological investigation could be performed due to resource limitations. No history was suggestive of tuberculosis or any contact. Emergency exploratory laparotomy was planned. Intraoperatively, an irregular lobulated mass of size approximately 13 × 11 × 9 cm, arising from mesentery encasing the bowel, about 100 cm proximal to ileocolic junction was found (Figs 1 and 2). The tumor was dissected and separated from the bowel. The encased bowel showed an area of gangrene with no signs of viability. Bowel was resected on either side about 5 cm from the source of tumor and anastomosis was done. An incidental Meckel's diverticulum was also found intraoperatively for which no intervention was done. Patient was shifted back to ICU after operation where the patient weaned off vasopressors

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in 24 hours. Patient was shifted to ward on postoperative day 3. The postoperative period was otherwise uneventful. Patient was discharged on postoperative day 9.



Fig. 1: Intraoperative picture showing mesenteric lipoma

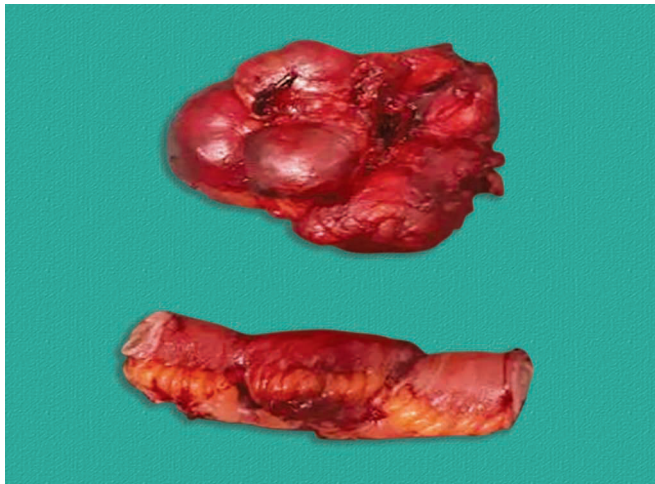


Fig. 2: Gross specimen of mesenteric lipoma with bowel segment resected

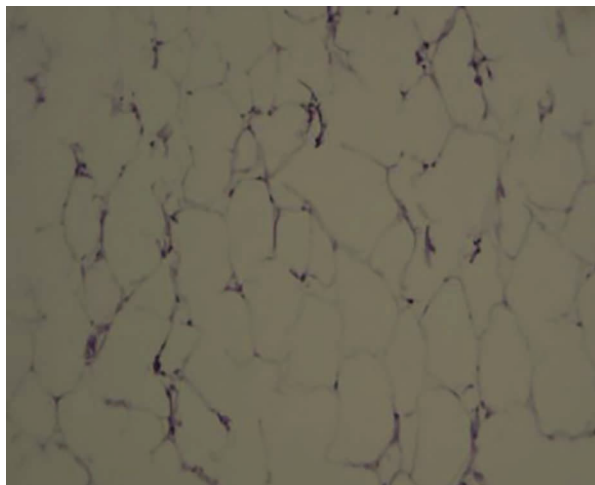


Fig. 3: Histopathology s/o mesenteric lipoma

HISTOLOGY REPORT

Microscopic examination revealed tumor comprising primarily of proliferating adipocytes with paucicellular fibrous septa and no signs of malignant changes (Fig. 3). These findings are suggestive of lipoma. The resected bowel showed evidence of chronic inflammation.

DISCUSSION

Mesenteric lipoma is a rather uncommon condition, with just about only 50 occurrences reported in the medical literature. Adults between the ages of 40 and 60 years are most commonly diagnosed with mesenteric lipoma. The tumor has no gender or ethnic preference.³ Despite the fact that mesenteric lipomas are frequently asymptomatic due to their soft composition, if the mass grows to a significant size or moves close to intestinal lumen

enough to compress it, symptoms of small bowel obstruction can arise as in our case. Some uncommon presentations of mesenteric lipoma as acute abdomen have been previously reported in medical literature. Dermoid cyst, liposarcoma, lymphangioma, lipoblastoma, lymphangiolipoma, and neuroblastoma are the main differential diagnosis.⁴ Mesenteric lipomas are generally incidental findings and are discovered by chance during any abdominal imaging procedure. Abdominal radiographs alone are not diagnostic. Ultrasound can be used to diagnose mesenteric lipoma as a primary method, however, it is an operator-dependent diagnostic tool.³ Until now, computed tomography scan has been the gold standard imaging tool for mesenteric lipoma detection due to its high detection rate and ability to provide distinct and exact anatomical landmarks.³ The primary treatment for mesenteric lipoma is total removal of the tumor without disrupting the intestinal loop, if possible.³ The optimum therapeutic option is exploratory laparotomy with en bloc excision of a massive mesenteric lipoma with or without intestinal resection.⁵ Due to lack of investigations and nonconclusive diagnosis, we adopted an en bloc excision with intestinal resection with 5 cm margins as part of the encased bowel was gangrenous. Also, we could not be sure of malignant potential of the tumor during operation. The resected loops were anastomosed. The histopathological report afterward confirmed a benign mesenteric lipoma.

CONCLUSION

Finally, mesenteric lipoma is a rare condition. It should be evaluated in the differential diagnosis of persistent ambiguous abdominal pain and distention, and it only rarely presents with an acute abdomen. It can grow to a large size, as in our case, and can cause acute obstruction.

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