ACG CASE REPORTS JOURNAL

VIDEO | COLON

Endoscopic Piecemeal Snare Resection of a Giant Colonic Lipoma in a Patient With Intestinal Obstruction

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CASE REPORT

A 71-year-old man presented with diffuse colicky abdominal pain, vomiting, and gradually progressive constipation. After stabilization of the patient's general condition, laboratory investigations were normal. Abdominal computed tomography with intravenous and oral contrast revealed a large lobulated, homogenous low-density fat mass measuring 12 × 5.4 cm at the right colon, suggestive of a right colonic giant lipoma (Figure 1).

Colonoscopy showed a giant yellowish soft lobulated mass almost occluding the lumen of the right colon (Figure 2). Submucosal fat tissue could be seen after a punch biopsy, indicating a giant lipoma. It had a wide-based pedicle that could be hardly reached after several attempts. The pedicle was injected with diluted epinephrine (1:10,000). Polypectomy snare was used (27 mm, medium oval-flexible; Boston Scientific, Marlborough, MA) and connected to the electrosurgical diathermy unit. The tip of the snare was used to open the covering mucosa; fat tissue bulged out and was excised piece by piece (Figure 3). To overcome the poor electrical conductivity of fat, we used a close-release technique. The snare was closed over part of the lipoma tissue for a while along with shaking and then released to allow better cutting. After all lipomatous tissue was excised, bleeding occurred from the feeding vessel. Thermal coagulation with the tip of the snare was used first, and then, an endoscopic clip (Cook Medical, Winston-Salem, NC) was applied with adequate hemostasis (Video 1; watch the video at http://links.lww.com/ACGCR/A12).

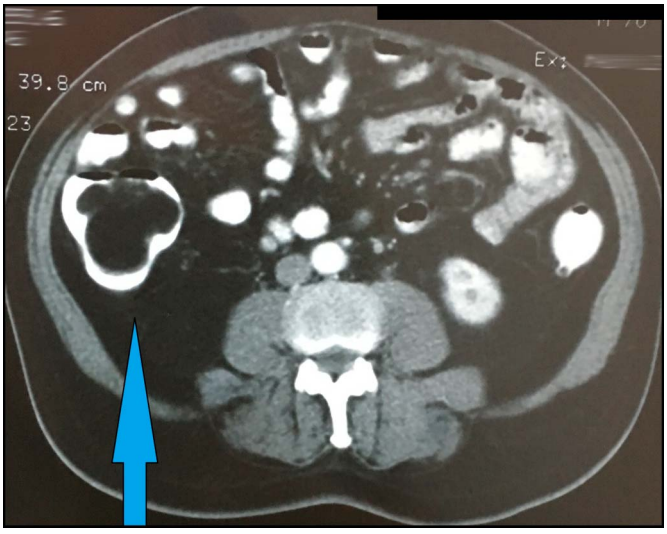

Figure 1. Abdominal computed tomography with intravenous and oral contrast showing a 12 × 5.4 cm homogenous low-density lipoma at the right colon.

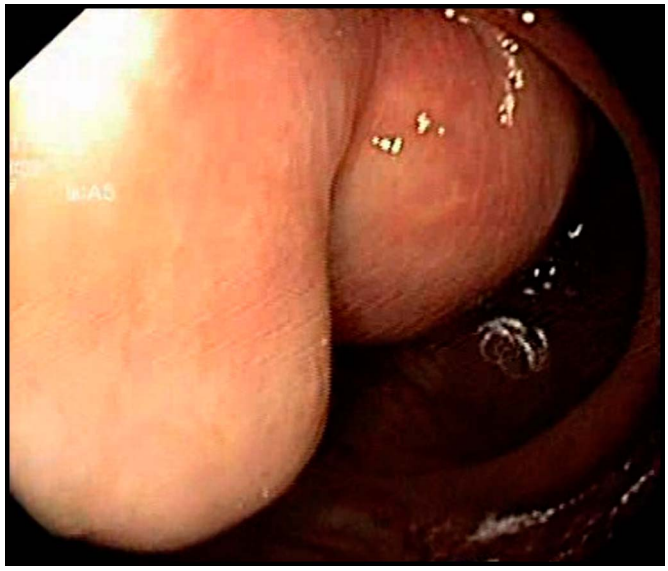

Figure 2. Colonoscopy showing a large lobulated yellowish giant lipoma occupying most of the lumen.

ACG Case Rep J 2019;6:e00190. doi:10.14309/crj.0000000000000190. Published online: August 29, 2019

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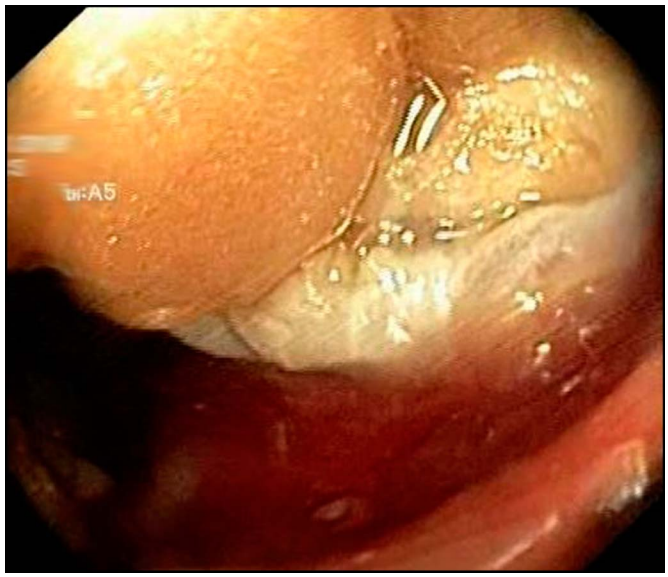

Figure 3. Fat tissue bulged after incision of the covering mucosa.

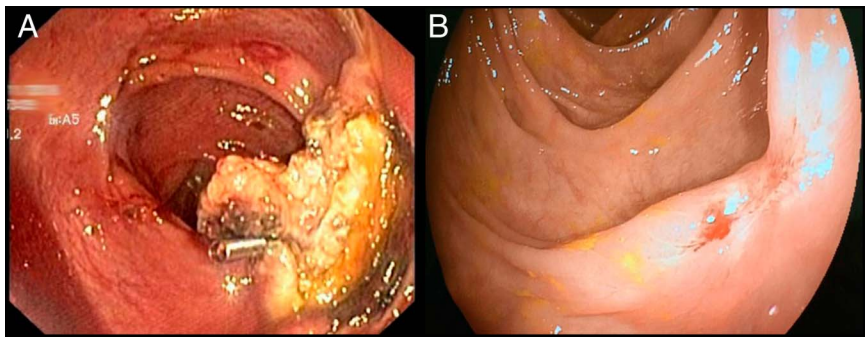

Figure 4. (A) Colonoscopy showing complete excision of the lipoma. (B) Follow-up colonoscopy after 3 months showing excision scar.

Video 1. Endoscopic video of piecemeal snare resection of a giant colonic lipoma. Watch the video at http://links.lww.com/ACGCR/A12.

The patient was admitted for 48 hours postprocedure and was started on a soft diet and parenteral prophylactic antibiotic. He was relieved from obstructive symptoms and reported no bleeding, abdominal pain, or fever. The pathological examination confirmed the diagnosis of fatty tissue with no malignancy. Follow-up colonoscopy after 3 months showed excision scar with no recurrence or stenosis (Figure 4).

Large colonic lipomas >4 cm are more likely to cause symptoms.[1] Endoscopic resection of giant lipomas carries a high risk of perforation and bleeding.[2] However, successful endoscopic resection of lipomas up to 11 cm has been reported.[3] Different techniques were used such as the unroofing technique for flat lesions, endoscopic submucosal dissection, endoscopic mucosal resection, deployment of endoloop around the base of a pedunculated lipoma, and either resection by snare polypectomy or "let go," resulting in ischemia and spontaneous separation.[3,4] To our knowledge, it is the largest lipoma reported to be endoscopically resected, using piecemeal snare resection, without major complications.

DISCLOSURES

Author contributions: M. Wahba edited the manuscript and is the article guarantor. G. Habib wrote and edited the manuscript.

Financial disclosure: None to report.

Informed consent was obtained for this case report.

Received April 13, 2019; Accepted June 26, 2019

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