Gastric lipoma: A rare cause of gastrointestinal bleeding


ABSTRACT

We report the case of a 58 year old lady, admitted to hospital with gastrointestinal bleeding. Oesophagogastroduodenoscopy demonstrated a protrusion in the gastric wall with erosion of the surface epithelium. Further investigations using a computed tomography scan revealed that the protrusion was in fact a submucosal lipoma, which required surgical intervention. This case has shown that a patient presenting with upper gastrointestinal bleeding requiring urgent endoscopic examination may also benefit from further investigations such as a computed tomography scan to confirm the diagnosis.

Keywords: Stomach, lipoma, bleeding, therapy.


Lipomas of the gastrointestinal tract are rare with an incidence of 0.1-0.3% at autopsy. They only comprise 15% of benign tumors in this region. Most of them are found in the colon (65-75%) and in the small intestine (20-25%). They very rarely occur in the oesophagus and in the stomach. Women are more vulnerable than men to this disease which is usually observed among patients in their fifties and sixties. Frequent, small tumors are: erosion of mucosa, ulceration, bleeding, invagination and obstruction. Malignant transformation is very rare.

Case Report. A 54 year old woman presented with dizziness and melena. She had neither smoked nor drunk alcohol. She had no history of peptic ulcer disease or nonsteroidal anti-inflammatory drugs treatment. She was hemodynamically stable with some abdominal tenderness but no peritonism. Investigations revealed a hemoglobin of 9.2 g/dl and hematocrit of 32%.

Upper gastrointestinal endoscopy demonstrated a subepithelial protrusion with mucosal erosion at the greater curvature in the corpus-antrum-region (Figure 1). Ultrasonography detected a homogenous and echodense mass in the submucosa of the posterior gastric wall. Computed tomography detected a homogenous fat like lesion 5.1 x 3.7 cm, (Figure 2), with minus 100 HU on the posterior stomach wall. This finding was interpreted as an intramural lipoma.

The patient, there after, underwent surgical therapy. After approaching the stomach by ventral gastrostomy, we removed a submucosal tumor the size of 5 x 4 cm from the posterior gastric wall. Both openings in the anterior and posterior gastric wall were each closed by two rows of running sutures. Frozen sections of the specimen confirmed the diagnosis of lipoma. The final histopathological report described a submucosal lipoma of 5.2 x 3.8 x 3.2 cm in size. The patient recovered uneventfully.

Discussion. Thirty five to fifty percent of upper gastrointestinal bleeding are due to ulcers, 12-25% due to acute gastric erosions and 10-30% result from oesophagus and fundal varices or both. Mallory-Weiss-Syndrome is responsible for 8-15%. More seldom reasons are oesophagitis and malignant
tumors both with 5-10%. Dieulafoy's ulcer, Verner-Morrison-Syndrome and hemorrhage from benign gastric tumors. This case report demonstrates that stomach lipoma was the reason for gastrointestinal bleeding. It can be mild due to pressure necrosis of the overlying mucosa and lead to chronic anemia, or it can be severe and require surgical intervention. Most patients are asymptomatic, while 75% of patients with lesions larger than 4 cm have complications; bleeding being the most common of them.

The primary diagnostic tools are: endoscopy, sonography and endosonography. Microscopic examinations of specimen taken do not always confirm the true diagnosis, because lipomas are usually in the submucosal region. The best method to achieve a correct diagnosis remains computed tomography. This procedure allows determination of size, location, relation to other tissues and tissue density. With regards to the therapy, Ackermann and Chungtai (1975) suggested local excision of lipomas in the gastric wall. This case report showed that surgical intervention is an indication in bleeding caused by stomach lipoma. Large tumors require gastric resection such as Billroth I or Billroth II. Occasionally, small pediculated tumors can be removed endoscopically.

References