Jejunal Lipoma, an Uncommon Cause of Gastrointestinal Bleeding

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Causes
Lipoma jejunal, uma causa incomum de hemorragia gastrointestinal

Palavras Chave
Hemorragia gastrointestinal · Cápsula endoscópica · Enteroscopia assistida por balão · Lipoma · Jejunum

Case Report

A 46-year-old male with a past history of arterial hypertension presented with asthenia and melaena. On examination, he presented tachycardia and elevated blood pressure. His blood tests showed microcytic hypochromic anaemia (haemoglobin 6.9 g/dL). After receiving 2 units of red blood cells, the patient underwent upper endoscopy, which was unremarkable except for gastric fundic gland polyps. Ileocolonoscopy revealed only terminal ileum nodular lymphoid hyperplasia.

A capsule endoscopy was done according to the diagnosis of obscure gastrointestinal bleeding. In the 2nd tercile, after a period of 30 min of slow progression, a large polypoid ulcerated mass causing significant luminal deformation was identified (Fig. 1). Antegrade double-balloon enteroscopy was performed and, in the proximal jejunum, a large diverticulum with an ulcerated border adjacent to an ulcerated lesion suggestive of subepithelial origin with approximately 8 cm (Fig. 2) was detected. On the proximal end, a tattoo was made as a reference mark. Extensive biopsies of the ulcer borders revealed only oedema, capillary proliferation, and regenerative features.

A CT scan revealed, in the proximal jejunum, a target sign with a central component compatible with adipose tissue, consistent...
with jejunal intussusception, although the aetiology could not be
identified. A segmental enterectomy with side-to-side jejunal
anastomosis was performed. Intra-operative macroscopic obser-
vation identified in the jejunum, just distally to the tattoo, a large
diverticulum and a 7.5-cm pedunculated ulcerated lesion (Fig. 3).
The histological evaluation showed a submucosal jejunal lipoma
with superficial ulceration (Fig. 4). The patient recovered com-
pletely and uneventfully.

Discussion

Lipomas are benign tumours of mesenchymal origin
that can arise throughout the gastrointestinal tract. The
most common localization is the colon (65–70%), fol-
lowed by the small intestine (20–25%) and, rarely, the oe-
osophagus and stomach [1–5]. Lipomas are the second
most common benign tumours of the small bowel, right
after leiomyoma [1].

Small bowel lipomas are typically solitary lesions,
more frequently located in the ileum and corresponding
to spheroid deposits of adipose tissue confined to the sub-
mucosal layer [2, 3, 5].

Due to its small size and indolent behaviour they usu-
ally do not cause symptoms [4]. However, when reaching
sizes above 2 cm, they can cause intussusception, bleed-
ing, pain, or biliary obstruction [1, 3–5].

Endoscopically, whether by device-assisted enterosco-
py or by capsule endoscopy, lipomas generally present as
rounded smooth yellow subepithelial tumours with a
wide base or pseudopedicle [1–3]. The “cushion sign” and
“naked fat sign” [1, 2] have also been classically described
as specific endoscopic features [1–4].

When symptomatic, there is indication for endoscop-
ic [3, 5] or surgical treatment [1, 2, 4]. Endoscopic rese-
cption in the small bowel has higher risks, especially with
classic snaring technique, requiring higher amounts of

Fig. 2. Double-ballon enteroscopy (Fujinon®) revealing a large jejunal ulcerated diverticulum (a, b) and imme-
diately after a large ulcerated polypoid lesion (c).

Fig. 3. During surgery, the jejunal tattoo was identified adjacent to a segment of decreased wall thickness and a
palpable intraluminal mass (a). Upon exposure of the lumen, these changes corresponded to a large diverticulum
and a 7.5 cm pedunculated ulcerated lesion (b).
energy due to poor electrical conductivity of adipose tissue. In this context, technical tricks such as the “loop-and-let-go” and “unroofing technique” have been described [3, 5].

Due to the atypical endoscopic features, dimension, and extensive ulceration, which did not allow for a prompt diagnosis, endoscopic treatment was not considered in the present case.

This case illustrates the difficulties in the diagnosis of obscure gastrointestinal bleeding and small bowel diseases even when all the different diagnostic tools available are used.

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Statement of Ethics

The authors declare that no patient data appear in this article.

Disclosure Statement

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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