# Giant lipoma of the descending colon

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## INTRODUCTION

Lipomas are relatively rare in the gastrointestinal tract. About two thirds occur in the colon, most frequently in the caecum (Taylor et al, 1990). Most lipomas are found incidentally. Larger tumours may cause intermittent episodes of intussusception (Liessi et al, 1996). Radiological investigation can make the diagnosis. The authors present the barium enema and computed tomography findings of a large lipoma in the descending colon.

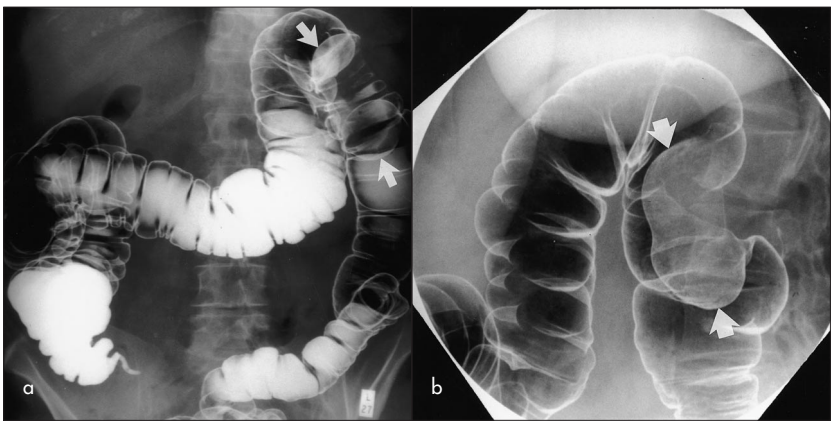



*Figure 1. Prone view (a) and spot erect right lateral view (b) double contrast barium enema showing smooth slightly lobulated mass just distal to the splenic flexure (arrows).*

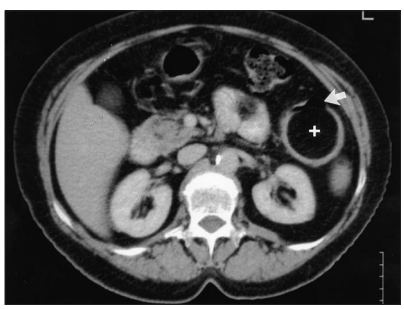
## DISCUSSION

Lipomas of the gastrointestinal tract are found most commonly in the large bowel, less commonly in the small bowel and rarely in the stomach and oesophagus (Hurwitz et al, 1967). In the colon, lipomas are mainly located in the caecum, ascending colon and sigmoid colon. Colonic lipomas are found in approximately 0.25% of autopsies (Weinberg and Feldman, 1955). They are more common in women than in men and occur most frequently in the fifth and sixth decades (Fernandez et al, 1983). The majority of colonic lipomas are small and asymptomatic. When the diameter of a lipoma exceeds 2 cm symptoms, usually pain, haemorrhage and altered bowel habit, are more frequent (Rogy et al, 1991). Pain may be chronic or recurrent as a result of intermittent intussusception, which tends to occur with pedunculated polyps greater than 4 cm in diameter (Liessi et al, 1996) and confusion with a carcinoma may occur. Stretching of the epithelium and mechanical trauma may lead to ulceration.

Colonic lipomas are soft and malleable, thus their configuration may be altered by peristalsis and external pressure (Hurwitz et al, 1967). A mass may not be palpated on physical examination as in this patient (Heiken et al, 1982). The majority are submucosal, with about one in ten being subserosal (Alponat et al, 1996).

Barium examinations demonstrate lipomas as being smooth margined filling defects, which may change in shape during the examination (Taylor et al, 1990). The high fat content of the

*Figure 2. Unenhanced axial computed tomography scan at a level with the renal hilae showing 5 cm diameter homogeneous hypodense intraluminal mass (+) in the descending colon. The –90 Hounsfield units density is that of fat. There is a small pocket of intraluminal gas lying anterior to the lesion (arrow).*




## CASE REPORT

A 62-year-old female patient was referred to the radiology department for investigation of a 6-year history of intermittent lower abdominal pain not related to food intake. There was no history of rectal bleeding or weight loss. Physical examination of the abdomen was unremarkable. Full blood count was normal.

Double contrast barium enema demonstrated a smooth, slightly lobulated mass in the descending colon just distal to the splenic flexure *(Figure 1)*. Computed tomography confirmed the presence of an intraluminal mass, which was of homogenous fat density (mean Hounsfield unit –90) *(Figure 2)*.

At surgery a pedunculated polypoid tumour was found at the splenic flexure. There was no evidence of intussusception or infiltration of the surrounding fat planes. Many superficial ulcers were present on the stretched mucosa of the mass. Segmental colonic resection of the splenic flexure was performed. Histologically the mass was composed of mature fat cells and interspersed fibrovascular septa, in keeping with a benign lipoma. The overlying colonic mucosa showed active inflammatory change. The patient's symptom of intermittent pain resolved after the surgery and at 3-month follow-up she remains well.

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tumour may give enhanced radiolucency. The smooth or lobular filling defect usually is sharply outlined because of reduced barium coating (Rogy et al, 1991). If the lipoma induces intussusception, a coiled-spring appearance or a filling defect stopping contrast flow may be demonstrated.

Lipomas may be diagnosed and if small dealt with therapeutically by endoscopy. Endoscopic removal of lipoma reduces the need for surgical intervention (Rogy et al, 1991).

Computed tomography is highly specific in diagnosing large colonic lipoma (Heiken et al, 1982). The lesions are well demonstrated with characteristic fatty densitometric values. In cases of intussusception the leading mass of the intussuscepted bowel segment on computed tomography may be demonstrated as being homogenous fat density. If there is infarction or necrosis within the lesion the mass may be of soft tissue attenuation leading to confusion with liposarcoma (Buetow et al, 1996).

Colonic lipomas are rare, but should be considered in the differential diagnosis of large-bowel tumours. Computed tomography may confirm the diagnosis, particularly if the lesion is large. HM


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## In the Public's View...

# Blame the mothers

So it's their own fault then. Smokers get lung cancer because they smoke, and cigarette packets sport stronger and stronger warnings. Smokers feel guilty. They sneak outside and hang around in doorways satisfying their habit, while self-righteous non-smokers regard them with a mixture of loathing and scorn.

Now we can do the same to women who don't breastfeed their babies. Because what possible other lesson can be drawn from the massive, and massively broadcast, meta-analysis that occupied nine pages of the *Lancet* in July? It was the lead story on Radio 4 that Friday morning, presented, as all news stories are, as if it were something new.

In a small book written for patients in 1994 (Baum et al, 1994), it says that the protective effects of pregnancy and lactation are obviously difficult to separate, but that there is some evidence that lactation is independently protective. The authors added that there was recent evidence from UK women that even a short period of breastfeeding was protective. Now, sure, the book is a populist one that doesn't cite references, but as one of its authors is Professor Michael Baum I'm prepared to take these statements on trust.

Even what was written in 1994 was not really new. Sex hormones have been implicated at least since the observation at the end of the 19th century that oophorectomy was effective palliation in advanced disease, and I remember that nuns have a high incidence of breast cancer from my medical student teaching.

People misunderstand what epidemiology can do. In general, its main use is connection, not explanation. Even when the connection is firm, as for cigarettes and lung cancer, epidemiology explains nothing. Further understanding requires the testing of hypotheses – looking for something in the tobacco that causes cellular changes, for example. Even that might not be enough; the firmest proof might require examination of lung cancer rates in two groups of smokers, one smoking normal cigarettes, and the other smoking cigarettes lacking the cellular toxin. But once epidemiology had established the cigarette–cancer link, it had nothing else to tell us.

So it is with breast cancer. Once we know hormones are important, it's time for the molecular scientists to set to work. They have not found the answer yet, and maybe they won't, but knowing more precisely by how much breastfeeding protects against breast cancer – the meta-analysis tells us the risk decreases by 4% for every 12 months – adds precisely nothing useful to our knowledge of breast cancer. There is nothing further we can tell mothers.

The breast is far better than the bottle for babies; is scaring mothers with an increased risk of cancer a sensible way of encouraging them to breastfeed? As Bruce Charlton wrote, epidemiology is 'a highly effective, albeit expensive mechanism for generating irrefutable health scares…compounded by the frequently moralistic or political aims that drive investigation'. This is yet more grist to the *Daily Mail*'s mill, always on the lookout for ways to criticize mothers deviating from the family norm. Perhaps they should give away 'Use it or lose it' skin transfers that mothers can apply to their breasts. HM


Baum M, Saunders C, Meredith S (1994) *Breast Cancer: a Guide for every Woman.* Oxford University Press, Oxford



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