Contents

contd. on page iii ...

For online submission of articles and viewing full text of publications, visit the Journal website at *www.indianjgastro.com*

This Journal is indexed by National Informatics Center, New Delhi, and indexed and abstracted by EMBASE/Excerpta Medica, Amsterdam, the Netherlands, and Index Medicus and Medline, Philadelphia, PA, USA

Contents (contd.)

Images

Endoscopic removal of giant colonic lipomas

Although usually asymptomatic, large lipomas (>2 cm) of the large bowel may occasionally present with bleeding, abdominal colicky pain, obstruction and intussusception. Because a majority of them are submucosal, endoscopic removal entails high risk of perforation, since the high water content requires a tremendous amount of heat to cut through. We describe our experience in endoscopic removal of giant (>2 cm) colonic lipomas in 6 patients with associated symptoms (Table).

The base of each lesion was injected with saline solution or a 1:10,000 solution of epinephrine (5-10 mL), and the lesion was then removed by monopolar electrosurgical snare resection. A large hexagonal snare (Olympus; Tokyo, Japan) was needed to ensnare the lesion near its base. In one patient (case 6), complete excision of the lesion could not be performed despite use of an excessive amount of monopolar current. The snare was removed from around the base of the lesion without difficulty. On the 12th day after attempted endoscopic removal, the patient reporting defecation of

Table: Patient characteristics

No	Dimension of polyp (cm)	Stalk (length x diameter)	Clinical presentation
1	2.3 x 2.5	No stalk	Rectal bleeding
2	4.0 x 2.5	1.0 x 0.5	Rectal bleeding
3	2.5 x 2.5	1.5 x 1.0	Massive hemorrhage
4	2.7 x 2.5	No stalk	Rectal bleeding
5	3.5 x 2.8	No stalk	Abdominal pain
6	4.4 x 4.0	1.0 x 2.0	Intussusception

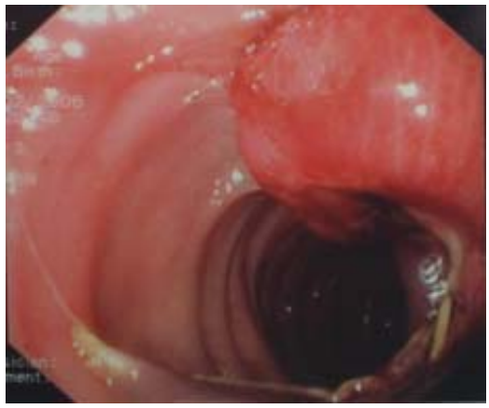

Fig: Large crater at site of auto-amputated lipoma

the polypoid mass. No complications were noted. All, except one, patients were discharged one hour after the procedure. On histologic examination, the resection specimens were submucosal lipomas; none of the specimens contained muscularis propria.

Follow-up endoscopy was performed at 3 months. In case 6, a large crater 4 cm in diameter (Fig) with residual adipose tissue in the margins was seen at the site of the resected lipoma. Follow-up sigmoidoscopy 11 months later was normal.

Colonoscopic polypectomy of large lipoma is difficult although possible in selected cases (especially if pedunculated). Various techniques (submucosal saline injection, endoscopic ultrasound) [1,2] have been advocated to reduce the reported high risk of perforation.[3] We did not perform endoscopic ultrasound before excision but we injected saline submucosally to create a protective cushion of fluid within the colonic wall. Removal of pedunculated lipomas does not provide any increased risk as compared with the removal of pedunculated adenomatous polyp.[4]

To our knowledge, this is the first report of lipoma expulsion in feces subsequent to failure of endoscopic removal. Raju *et al*[5] reported placement of a detachable nylon loop in the stalk of a large lipoma that was left in place; the lipoma regressed progressively, probably due to ischemia.

Georgia Lazaraki, Dimitrios Tragiannidis,
Anestis Tarpagos, Dimitrios Tzilves,
Ioannis Pilpilidis, Ioannis Katsos

Department of Gastrointestinal Oncology, Theagenion Cancer Hospital, Thessaloniki, Greece

References

1. Tamura S, Yokoyama Y, Morita T, Tadokoro T, Higashidani Y, Onishi S. "Giant" colon lipoma: what kind of findings are necessary for the indication of endoscopic resection? *Am J Gastroenterol* 2001;96:1944-6.
2. Kim CY, Bandres D, Tio TL, Benjamin SB, Al-Kawas FH. Endoscopic removal of large colonic lipomas. *Gastrointest Endosc* 2002;55:929-31.
3. Pfeil SA, Weaver MG, Abdul-Karim FW, Yang P. Colonic lipomas: outcome of endoscopic removal. *Gastrointest Endosc* 1990;36:435-8.
4. Stone C, Weber HC. Endoscopic removal of colonic lipomas. *Am J Gastroenterol* 2001;96:1295.
5. Raju GS, Gomez G. Endoloop ligation of a large colonic lipoma: a novel technique. *Gastrointest Endosc* 2005;62:988-90.

Correspondence to: Dr Lazaraki, Gastroenterologist, Papadaki 14 str, 54248 Thessaloniki, Greece. Fax:: 30 (23) 1089 8408. E-mail: lazarakg@yahoo.com