Endoscopic diagnosis and treatment of a giant duodenal lipoma presenting with gastrointestinal bleeding

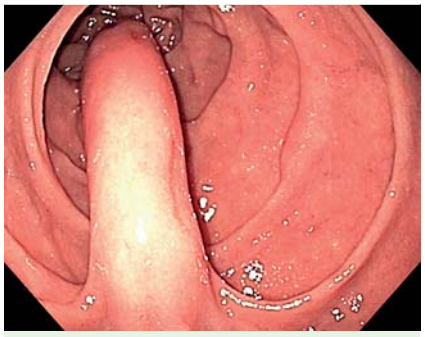

Fig. 1 Endoscopic view of a 3-cm long polypoid lesion with multiple ulcerations in the second part of the duodenum in a 66-year-old man with fatigue and acute upper gastrointestinal bleeding.

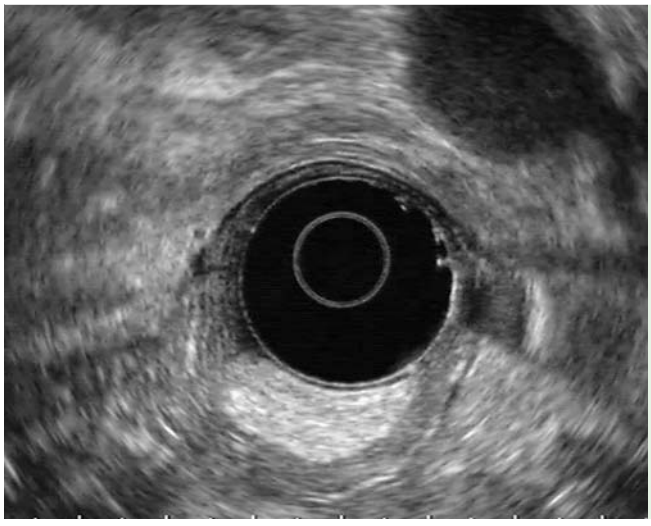

Fig. 2 Endoscopic ultrasound showing a hyperechoic lesion (11 × 19 mm) originating from the submucosa in the duodenal wall.

A 66-year-old man presented with fatigue and acute upper gastrointestinal bleeding (hemoglobin 92 g/L). He had melena but no signs of hematemesis. Upper gastrointestinal endoscopy revealed a 35 × 15-mm large polypoid lesion with multiple ulcerations in the second part of the duodenum (▶ **Fig. 1**). No biopsy samples were taken due to the risk of bleeding. The diagnosis was unclear and the patient underwent endoscopic ultrasound, which demonstrated a hyperechoic lesion measuring 11 × 19 mm in diameter in the submucosa in the duodenal wall with intact muscularis propria (▶ **Fig. 2**), suggestive of a lipoma. A subsequent capsule endoscopy excluded distal causes of bleeding in the small intestine. Next, the lesion was removed endoscopically using an endoloop and snare without any complication (▶ **Fig. 3**). The resected lesion exhibited multiple ulcerated areas (▶ **Fig. 4**). Histological examination demonstrated a duodenal lipoma with large blood vessels in contact with these ulcerated areas (▶ **Fig. 5**).

Duodenal lipomas are extremely rare and constitute only one in 600 benign tumors of the gastrointestinal tract [1]. Duodenal lipomas are usually asymptomatic but larger ones can, in rare cases, cause abdominal pain, intestinal obstruction, or hemorrhage [2, 3]. Symptomatic duodenal lipomas should be removed. The current recommendation is endoscopic excision, unless this is technically difficult and warrants surgical excision. Nonetheless, this unusual case with a duodenal lipoma causing upper gastrointestinal bleeding underlines the clinical importance of endoscopic ultrasound in the workup of patients with unclear submucosal lesions in the gastrointestinal tract.

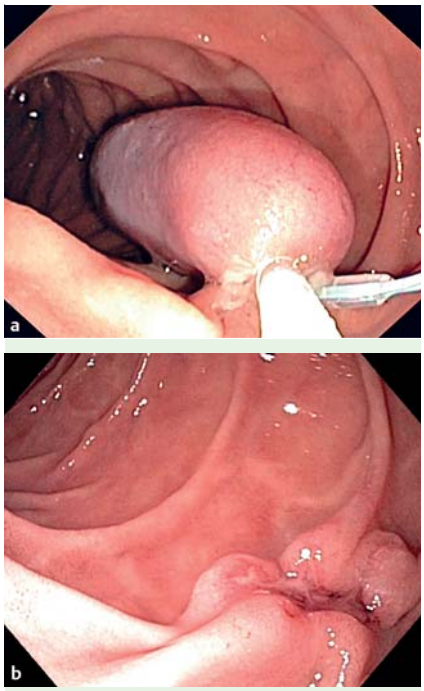

Fig. 3 **a** The lesion was removed using an endoloop and snare (endocut mode effect 2 and forced coagulation effect 2, 30 W, VIO 300 D; ERBE Elektromedizin, Tubingen, Germany). **b** The resection site 24 hours after polypectomy.

Fig. 4 The resected specimen showing multiple ulcerated areas.

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Competing interests: None

Henrik Thorlacius[1], Håkan Weiber[1], Otto Ljungberg[2], Jörgen Nielsen[3], Ervin Toth[3]

[1] Section of Surgery, Department of Clinical Sciences, Malmö, Skåne University Hospital, Lund University, Malmö, Sweden
[2] Section of Pathology, Department of Clinical Sciences, Malmö, Skåne University Hospital, Lund University, Malmö, Sweden
[3] Section of Gastroenterology, Department of Clinical Sciences, Malmö, Skåne University Hospital, Lund University, Malmö, Sweden

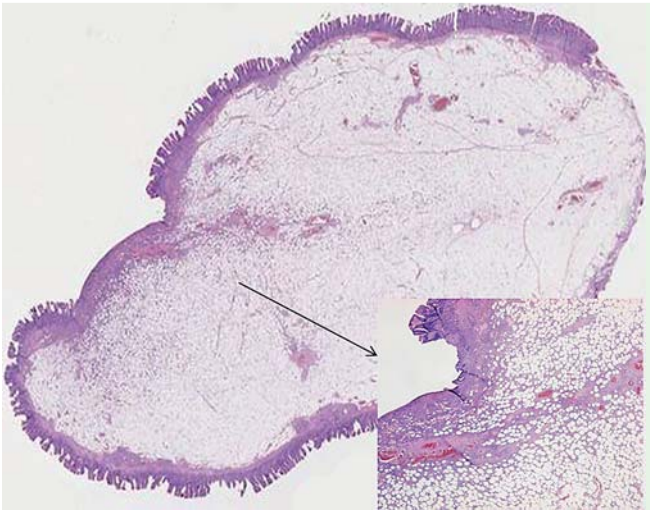

Fig. 5 Histological section from the lesion showing adipose cells compatible with duodenal lipoma and large blood vessels in contact with the ulceration (arrow).

References

1 *Mayo CW*, *Pagtaluman RJG*, *Brown DJ*. Lipoma of the alimentary tract. Surgery 1963; 53: 598 – 603
2 *Tung CF*, *Chow WK*, *Peng YC* et al. Bleeding duodenal lipoma successfully treated with endoscopic polypectomy. Gastrointest Endosc 2001; 54: 116 – 117
3 *Blanchet MC*, *Arnal E*, *Paparel P* et al. Obstructive duodenal lipoma successfully treated by endoscopic polypectomy. Gastrointest Endosc 2003; 58: 938 – 939

Bibliography

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Corresponding author

Henrik Thorlacius
Department of Clinical Sciences, Malmö
Section of Surgery
Skåne University Hospital
Lund University
S-205 02 Malmö
Sweden
Fax: 46-40-336207
henrik.thorlacius@med.lu.se