A 52-year-old white man without co-morbidities presented with a 6-year history of recurrent abdominal pain and episodes of melena twice a week for the past year. He was started on oral iron sulfate supplements and had already received a blood transfusion.

Findings from physical examination were normal. The hemoglobin level was 10.8 g/dL. Gastroduodenoscopy and colonoscopy revealed several smooth sessile and pedunculated lesions covered by normal mucosa, which are characteristics of lipomas, and with no signs of bleeding. Double-balloon endoscopy (DBE) revealed innumerable similar subepithelial lesions, measuring 1–4 cm in diameter, throughout the entire small bowel (Video 1). In the distal jejunum, multiple pedunculated lesions were seen, with twisted pedicles, superficial erosion, and covered by fibrin, suggestive of vascular damage (Fig. 1, Fig. 2).

Abdominal computed tomography scan showed multiple hypodense lesions compatible with lipomas, and areas of intussusception with mild proximal small-bowel dilation (Fig. 3). The patient underwent laparoscopy, which confirmed irreducible intussusception, and led to minilaparotomy with four enterotomies and resection of multiple lipomas (Fig. 4, Fig. 5). A total of 26 lesions were resected, including some with signs of bleeding. Histopathology confirmed the diagnosis of lipomatosis (Fig. 6).

The patient was discharged 3 days after surgery, and at the 5-month follow-up visit he remained asymptomatic with a hemoglobin level of 12.9 g/dL.

Lipomas of the gastrointestinal (GI) tract are benign tumors and are usually solitary; however, they can rarely present as GI lipomatosis [1]. Although mostly asymptomatic, GI lipomas may cause symptoms, including obstruction as a result of intussusceptions, and GI bleeding [2, 3]. Treatment consists of surgical or endoscopic resection. Endoscopic options include mucosal or submucosal resection, unroofing technique, and application of an endoloop or endoclip [4, 5].

This case demonstrated the endoscopic and laparoscopic characteristics of diffuse GI lipomatosis. DBE was essential to the diagnosis, and surgical resection resolved the intussusception and obscure GI bleeding.

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Fig. 5 At laparotomy, an area of intussusception was observed.

Fig. 6 Histological analysis of the surgical specimens revealed lipomatosis (hematoxylin and eosin, × 10).