Endoscopic resection of a colonic lipoma presenting with hematochezia

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Bakcground: Colonic lipomas are uncommon, benign, fatty tumors that are usually silent clinical course, so they are often found incidentally at colonoscopy, surgery or autopsy. But Lipomas larger than 2cm can cause symptoms such as abdominal pain, changes in bowel habits, rectal bleeding, obstruction, intussusception or perforation. We herein report on a case of large lipoma as presented with hematochezia and obstruction. **Case report:** A 31-year old woman was visited our hospital presenting hematochezia and lower abdominal pain. Abdominal computed tomography shows intussusception of sigmoid colon with 3cm sized intramural lipoma. Sigmoidoscopy was done for an observation and reduction and it shows a huge polypoid tumor obstructing the lumen with bleeding and surrounding an edematous mucosa. Follow up sigmoidoscopy was done and showed a 3cm sized smooth and pedunculated polyp. We used a standard technique of polypectomy, preceded by submucosal injection with indigo-carmine and epinephrine solution, and fully resected large lipoma. No bleeding or perforation was noted. Pathology examination showed submucosal lipoma with mucosal ulceration. **Discussion:** In the past, endoscopic resection of colonic lipoma was thought to be higher risk of perforation and bleeding. But, several case reports shows colonic lipoma larger than 2 cm can be safely removed using a standard polypectomy technique. Our case shows fully resected lipoma, using safe and effective standard polypectomy technique.

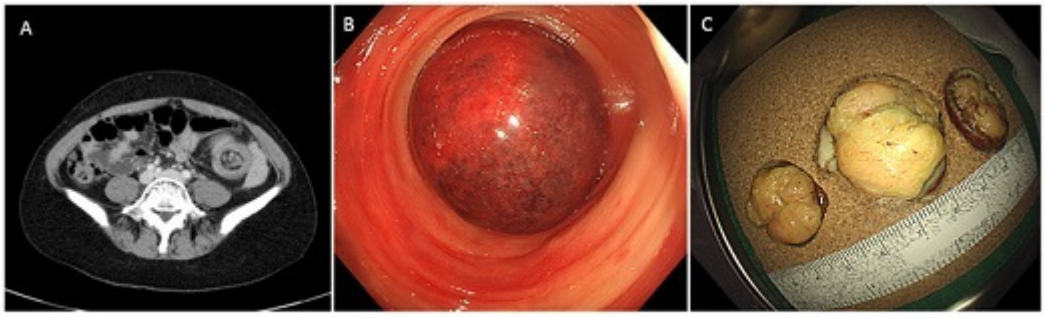

Fig 1. A) Computed tomography shows intussusception of sigmoid colon with intramural lipoma. B) Sigmoidoscopy shows a round, smooth, bleeding and huge polypoid tumor obstructing the lumen. C) 3 specimen was obtained for pathology

Cases of Polyarteritis Nodosa with Involvement of Superior Mesenteric Artery

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Polyarteritis nodosa (PAN) is a systemic necrotizing vasculitis affecting medium or small-sized arteries. Its diagnosis may bedelayed because it is a rare disease, and patients presenting with PAN demonstrate variable clinical manifestations and non-specific laboratory abnormalities. Gastrointestinal involvement occurs in 14～65% of patients with PAN and is a significant cause of morbidity and mortality. Thus, early diagnosis is very important in PAN with gastrointestinal involvement. Two 44 years old men visited local hospital with acute abdominal pain. There was no specific laboratory abnomality and abdominal CT. But there symptom was not improved by conservated treatment. After one week, they visited our hospital, inital laboratory finding was normal but perivascular cuffing mass was noted around diffuse irregular narrowing superior mesenteric artery and its jejunal branch in abdominal CT. Serum anti-nuclear antibody and anti-neutrophil cytoplasmic antibody was normal. So we diagnosed PAN with SMA involvement. Patient had treated with immunosuppressant and systemic steroid. Symptom and CT finding was improved after treatment. We report a cases of rapidly progressive PAN presenting with abdominal pain, having failed conservative treatment.

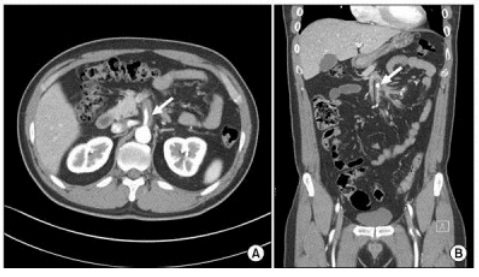

Fig. 1. Follow up abdominal CT finding. (A) High density perivascular cuffing mass (arrow) is noted around diffuse irregular narrowing superior mesenteric artery and its jejunal branch. (B) An 8-mm-sized saccular aneurysmal dilatation (arrow) is seen on the inflamed superior mesenteric artery.