

## Giant Mesenteric Lipoma: Rare Cause of Chronic Pain Abdomen

Mittal Atul Kumar<sup>1\*</sup>, Pandey Abhinav<sup>2</sup>, Chhabra Sanjeev<sup>3</sup>, Garg Prashant<sup>4</sup>, Kankaria Jeevan<sup>5</sup>,  
Jenaw Rajkamal<sup>6</sup>

<sup>1-3</sup>Resident, <sup>4</sup>Senior resident, <sup>5</sup>Associate Professor, <sup>6</sup>Professor, Department of Surgery, S.M.S. Medical College and Hospital, Jaipur, Rajasthan, India

### \*Corresponding Author:

Name: Dr. Atul kumar Mittal

Email: [a.mittal007@gmail.com](mailto:a.mittal007@gmail.com)

**Abstract:** Lipomas can occur anywhere in the body but origin from intestinal mesentery is very rare. Exact prevalence of lipomas is unknown because of its silent nature. Mesenteric lipomas are mostly asymptomatic but sometimes associated with abdominal pain, abdominal lump and features of intestinal obstruction. A 52-yr-old man presented with abdominal pain which was on left lower abdomen and colicky in nature. Patient has history of pain abdomen since last 1yr. But it had worsened over the past 2 months. CECT scan of whole abdomen revealed a large ill defined fat density lesion noted involving mesentery on left side below the stomach extending upto suprapubic region and crossing the midline. Patient planned for open exploration. Per operative findings were: (a) an encapsulated, yellowish pink mass originating from the ileal mesentery in the lower abdominal cavity, (b) The mass extended from supra pubic region to hypogastric region and was free of any adhesions or signs of necrosis, (c) Lymphadenopathy, ascitis or fluid collection was not seen, (d) Surgical removal of the fatty mass was performed without difficulty. The resected mesenteric mass was a soft, yellow mass and 30×15×30 cm in size and weight 4.5 kg. Patient discharged on post-op day 2 and followed up in surgical outdoor for 5 month. Due to silent nature of these mesenteric lipomas, prevalence of mesenteric lipomas is unknown, but it's certainly higher than reported. Higher incidence of Lipomas is seen in obese and diabetic people. They present as a slow-growing, non-lobulated, soft, mobile mass that does not penetrate into surrounding organs. On enlargement enough symptoms include anorexia, abdominal distension, weight loss, abdominal pain, constipation, and sensation of fullness, especially after meals. Pain abdomen is caused by pressing upon the intestinal loops when tumour is near the intestinal lumen. The size of the mesenteric lipoma in our patient was one of the largest reported in the literature.

**Keywords:** Giant mesenteric lipoma, Intra-abdominal lipoma, CECT abdomen, Chronic pain abdomen.

### INTRODUCTION

Lipomas can occur anywhere in the body but origin from intestinal mesentery is very rare [1, 2]. Because of the silent nature the exact prevalence of lipomas is unknown [3]. Mesenteric lipomas are mostly asymptomatic but sometimes associated with abdominal pain, abdominal lump and features of intestinal obstruction [4].

### CASE REPORT

A 52-yr-old man presented with abdominal pain which was on left lower abdomen and colicky in nature. Patient has history of pain abdomen since last 1yr. But it had worsened over the past 2 months. Pain aggravated after eating meals and associated with abdominal distension. RFT and LFT'S were normal.

CECT scan of whole abdomen revealed a large ill defined fat density lesion noted involving mesentery on left side below the stomach extending upto suprapubic region and crossing the midline and was extending on right side. Multiple foci of calcification,

internal septations were noted with in the lesion. Size was 22X11.2X27 cm and it was displacing small bowel loops on right side.

Patient planned for open exploration. Per operative findings were:

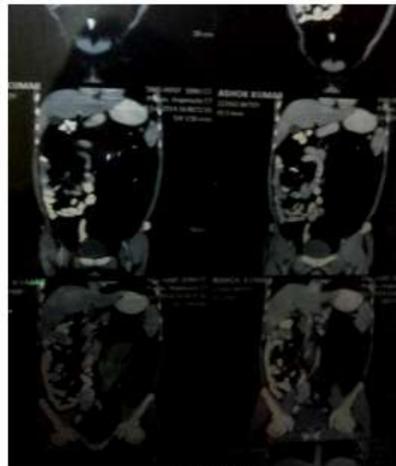
- An encapsulated, yellowish pink mass originating from the ileal mesentery in the lower abdominal cavity.
- The mass extended from supra pubic region to hypogastric region and was free of any adhesions or signs of necrosis.
- Lymphadenopathy, ascitis or fluid collection was not seen.
- Surgical removal of the fatty mass was performed without difficulty. The resected mesenteric mass was a soft, yellow mass and 30×15×30 cm in size and weight 4.5 kg. Microscopically, the mass was characterized by homogenous mature adipose tissue without cellular atypia, which was compatible with the diagnosis of a mesenteric

lipoma. Patient discharged on post-op day 2 and

followed up in surgical outdoor for 5months.



(Fig. 1)



(Fig. 2)

**Fig. 1 & 2: CECT abdomen film showing CECT scan of whole abdomen**



(Fig. 3)

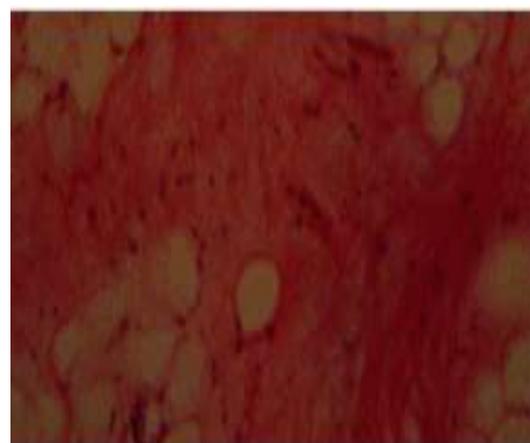


(Fig. 4)

**Fig. 3 & 4: Showing an encapsulated, yellowish pink mass originating from the ileal mesentery in the lower abdominal cavity**



**Fig. 5: The resected mesenteric mass was a soft, yellow mass and 30×15×30 cm in size and weight 4.5 kg**



**Fig. 6: Showing microscopically, characterized by homogenous mature adipose tissue without cellular atypia, compatible with the diagnosis of a mesenteric lipoma**

## DISCUSSION

Due to silent nature of these mesenteric lipomas, prevalence of mesenteric lipomas is unknown, but it's certainly higher than reported. Higher incidence of Lipomas is seen in obese and diabetic people [5, 6]. They present as a slow-growing, non-lobulated, soft, mobile mass that does not penetrate into surrounding organs [1, 5]. When they enlarge enough symptoms include anorexia, abdominal distension, weight loss, abdominal pain, constipation, and sensation of fullness, especially after meals. Pain in abdomen is caused by pressing upon the intestinal loops when tumour is near the intestinal lumen. But obstruction is rarely seen due to soft consistency of the lipoma and liquid nature of small bowel contents [5]. Mesenteric lipomas may pose diagnostic difficulties due to normal lab findings and vague symptoms [6].

The size of the mesenteric lipoma in our patient was one of the largest reported in the literature. Radiological examination had suggested that the possible diagnosis and the best definitive diagnostic procedure is CECT abdomen [7, 8]. Definitive treatment for mesenteric lipoma has not been established. Entire resection with, or if possible without, is the treatments of choice [6].

## CONCLUSION

Mesenteric lipoma is a very rare location of lipoma, and often missed due to their silent nature, having the tendency to grow to large proportions and numbers [6].

CT abdomen is the useful for diagnosis [7]. Complete surgical excision is the only treatment, with a very good prognosis [6]. The recurrence rate of lipomas is less than 5% and is usually due to incomplete excision [9].

## REFERENCES

1. Prando A, Wallace S, Marins JL, Pereira RM, de Oliveira ER, Alvarenga M; Sonographic features of benign intraperitoneal lipomatous tumor in children: report of 4 cases. *Pediatr Radiol.*, 1990; 20(8): 571–574.
2. Takagi Y, Yasuda K, Nakada T, Abe T, Saji S; Small bowel volvulus caused by a lipoma of the mesentery showing a distinct pattern on preoperative computed tomography. *Dis Colon Rectum.*, 1998; 41(1):122–123.
3. Kshirsagar AY, Nangare NR, Gupta V, Vekariya MA, Patankar R, Mahna A *et al.*; Multiple giant intra abdominal lipomas: A rare presentation. *Int J Surg Case Rep.*, 2014; 5(7): 399-402.
4. Kaniklides C, Frykberg T, Lundkvist K; Pediatric mesenteric lipoma; an unusual cause of repeated abdominal pain. A case report. *Acta Radiol.*, 1998; 39(6): 695–697.
5. Ilhan H, Tokar B, İşıksoy S, Koku N, Pasaoglu O; Giant mesenteric lipoma. *J Pediatr Surg.*, 1999; 34(4): 639–640.
6. Cha JM, Lee J, Joo KR, Choe JW, Jung SW, Shin HP *et al.*; Giant mesenteric lipoma as an unusual cause of abdominal pain: A case report and a review of the literature. *J Korean Med Sci.*, 2009; 24(2): 333–336.
7. Pereira JM, Sirlin CB, Pinto PS, Casola G; CT and MR imaging of extrahepatic fatty masses of the abdomen and pelvis: techniques, diagnosis, differential diagnosis, and pitfalls. *Radiographics.* 2005; 25(1): 69–85.
8. Méndez-Uriburu L, Ahualli J, Méndez-Uriburu J, Méndez-Uriburu M, Fajre L, Méndez-Uriburu F *et al.*; CT appearances of intraabdominal and intrapelvic fatty lesions. *AJR Am J Roentgenol.* 2004; 183(4): 933–943.
9. Livne PM, Zer M, Shmuter Z, Dintsman M; Acute intestinal obstruction caused by necrotic mesenteric lipoma: a case report. *Am J Proctol Gastroenterol Colon Rectal Surg.*, 1981; 32(11): 19–22.