

Lipomatosis of the Ileocaecal Valve: A Case Report

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Abstract

The lipomatosis of ileocecal valve is characterized by a diffuse infiltration of fatty tissue, most often in the submucous layer. The ileocecal valve becomes enlarged. Lack of distinct capsule differentiate the fat in this condition from a true lipoma. As lipomatosis of the ileocecal valve is a rare condition, with doubtful pathogenesis and somewhat controversial therapy the case is reported. It must be recognized and differentiated from true tumours.

Key words: Lipomatosis, Ileocecal valve, Crohn's disease, Computed Tomography, Ultrasound.

Introduction

Lipomatosis of the gastrointestinal tract is a rare condition. The term lipomatosis describes focal proliferation of normal fat in the soft tissue including the mediastinum, kidneys, pelvis or intestine (1). Intestinal lipomatosis is the infiltration of the submucosa by mature fat tissue without tumour formation (2). A number of synonyms have been applied including lipohyperplasia, submucosal fatty accumulation, fatty degeneration, hypertrophy of the ileocecal valve (3) and the ileocecal valve syndrome (4).

Case Report

A 58-year-old female patient presented with frequent lower abdominal pain on right side for 6 months came to Accident and Emergency Department of Suri Seri Begawan Hospital at Kuala Belait, Brunei. There was no history of nausea or vomiting. On examination there was tenderness at suprapubic area, no guarding and bowel sounds were positive. Ultrasound of abdomen was done and it was normal. She was referred to Surgical Out Patient Department and advised for CT scan of abdomen. CT scan showed a fat density area of about 2.9 x 2.2 cm at ileocecal region and multiple uncomplicated diverticula in colon (Figure A & B).

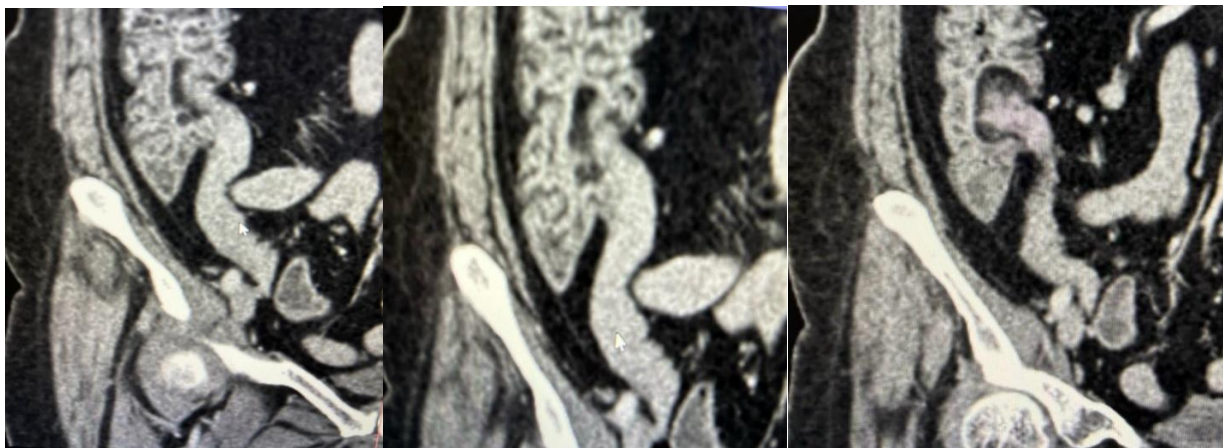


Figure A - Coronal CT scan

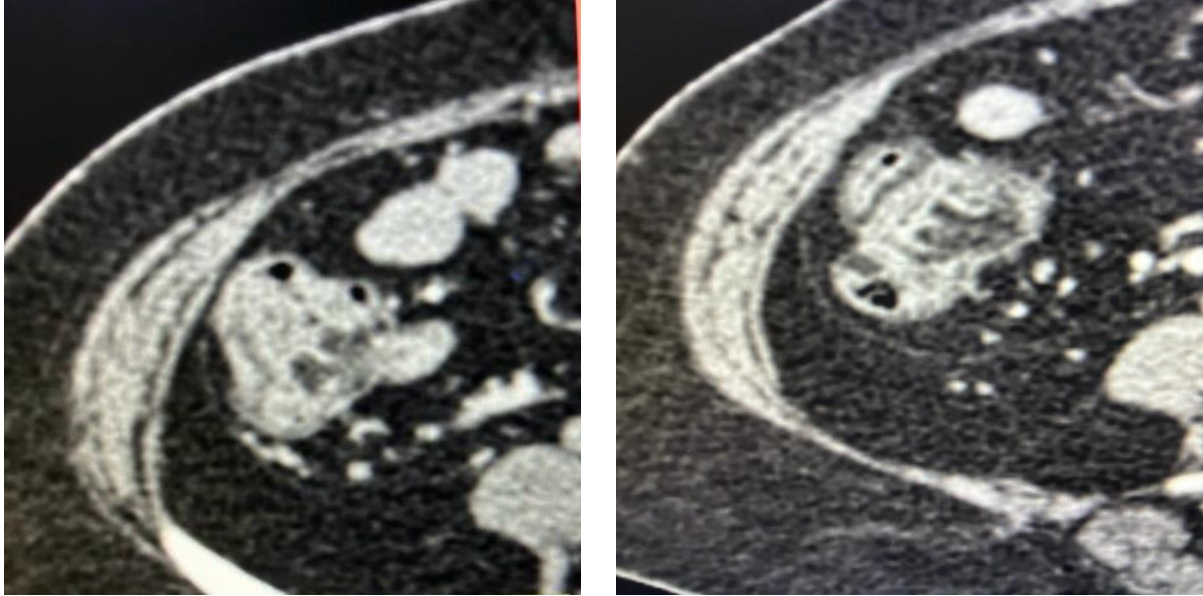


Figure B - Axial CT scan

Discussion

Abnormal fatty tissue deposits in the intestine can be seen in the forms of single or multiple lipomas or diffuse adipose tissue infiltration of the submucosa without tumour formation. The later one is called lipomatosis. Lack of encapsulation differentiates it from lipoma (5). The fatty tissue proliferation and deposition is usually limited to the submucosal layer, but it may extend to the serosa and mesenteric fat. The cause of fat deposition is not exactly known (2).

Intestinal lipomatosis shows no sex predominance and it occurs usually after the 4th decade of life (1,5,6). There is no predilection of site. Majority is asymptomatic. When they reach bigger sizes, symptom starts (7). Most common manifestations are nonspecific abdominal pain, constipation, diarrhoea and bleeding (5,7,8). Abdominal pain was the only symptom in our case, there was no gastrointestinal bleeding. Obstruction, intussusception and massive haemorrhage are rare complications (7). Our case was treated conservatively.

Ileocecal area may be affected by many pathologic conditions such as benign and malignant tumors, inflammatory processes like appendicitis, diverticulitis, Crohn's disease and infectious diseases. So differential diagnosis is important in the lesions detected in this area. MDCT is the best imaging modality considered to evaluate ileocecal region (9). Intestinal lipomatosis is shown as well-defined fat density area (attenuation between -80 and -120HU) (10). It can be differentiated from true lipoma, which appears as an asymmetric mass whereas lipomatosis manifests as symmetric enlargement (9,10). Thumb printing of fluid containing bowels is seen in the coronal magnetic resonance images. The same sign can also be seen in intestinal ischemia, but intestinal wall thickness is normal in lipomatosis (1). Barium enema may show a radiolucent filling defect.

Conclusion

No treatment is required in ileocaecal lipomatosis since it is usually asymptomatic. When it reaches big sizes and obstruction develops, surgical procedures may be necessary (11).

Conflict of interest: None.

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