

SUBMUCOSAL ILEAL LIPOMA: A RARE CAUSE OF SMALL BOWEL OBSTRUCTION IN A YOUNG ADULT

General Surgery

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ABSTRACT

Ileal lipomas are rare benign tumors of mesenchymal origin and represent an uncommon cause of small bowel obstruction. We report the case of a 24-year-old male who presented with acute abdominal pain, distension, and vomiting. Clinical examination and imaging suggested small bowel obstruction. Exploratory laparotomy revealed a submucosal lipoma in the ileum acting as a lead point for obstruction. Segmental resection of the affected ileum with end-to-end anastomosis was performed. Histopathological examination confirmed the diagnosis of submucosal lipoma composed of mature adipose tissue without atypia. The postoperative course was uneventful, and the patient was discharged in stable condition. This case underscores the importance of considering rare benign etiologies such as ileal lipoma in the differential diagnosis of intestinal obstruction, particularly in young patients with no prior surgical history. Prompt surgical management provides excellent outcomes and prevents potential complications like intussusception or ischemia.

KEYWORDS

Ileal Lipoma; Small Bowel Obstruction; Submucosal Tumor; Intestinal Obstruction; Case Report

INTRODUCTION

Lipomas of the gastrointestinal tract are benign tumors composed of mature adipose tissue, accounting for 2–4% of benign intestinal neoplasms [1]. The colon is the most frequent site, while the small intestine, particularly the ileum, is rarely involved [2]. Ileal lipomas are often asymptomatic and discovered incidentally; however, large lesions can lead to complications such as intussusception, bleeding, or mechanical obstruction [3]. We report a rare case of submucosal ileal lipoma presenting with acute intestinal obstruction in a young adult, managed successfully by surgical resection.



Fig A: Ileal Swelling with Collapsed Distal Loops

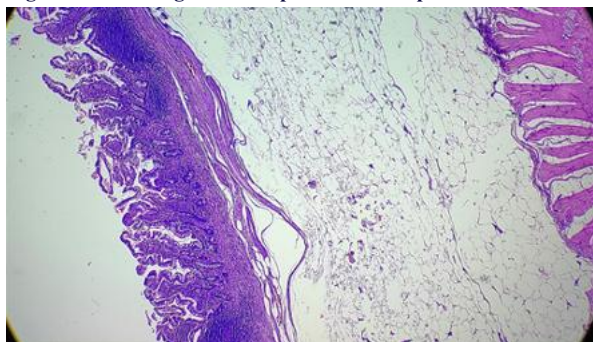


Fig B: Submucosal Lipoma (H&E)

Case Presentation

A 24-year-old male presented with complaints of chronic abdominal pain associated with two to three episodes of vomiting and constipation for the past two months. He had been taking medications such as painkillers and antacids from a local pharmacist, but his symptoms did not subside. Due to recurrent vomiting and spasmodic

abdominal pain, his oral intake had decreased, and he was eating less out of fear of triggering symptoms.

On clinical examination, the abdomen was soft with mild tenderness in the right iliac fossa (RIF). A provisional diagnosis of appendicitis or other RIF pathology was considered. Blood investigations and ultrasonography (USG) of the abdomen were performed, which revealed no significant abnormalities except probe tenderness and mild electrolyte imbalance secondary to vomiting. Per rectal examination showed normal anal tone, with no evidence of internal or external hemorrhoids, and the rectum was empty.

The patient was admitted and started on conservative management, including intravenous fluids and correction of electrolyte imbalance. A contrast-enhanced computed tomography (CECT) scan of the abdomen and pelvis with oral and intravenous contrast revealed a well-defined intraluminal mass in the distal ileum measuring approximately 3.6×2.5 cm, with collapse of the distal ileal loops.

A multidisciplinary discussion involving the departments of General Surgery, Gastroenterology, Radiology, and Pathology was conducted regarding the management of the ileal mass. It was decided to proceed with surgical intervention — excision of the mass with ileal resection and primary end-to-end anastomosis — after appropriate preoperative optimization.

DISCUSSION

Small intestinal lipomas are rare, representing less than 2% of all gastrointestinal lipomas [4]. Among these, the ileum is an infrequent site. Most lipomas arise from the submucosa (90%), while subserosal or intramucosal origins are less common [5]. They are typically slow-growing and asymptomatic; however, when they exceed 2 cm, they may cause obstruction or intussusception [6].

In the present case, the lipoma acted as a lead point for mechanical obstruction without intussusception. The clinical presentation of small bowel lipoma is nonspecific, and imaging plays an important role in diagnosis. Computed tomography (CT) scan demonstrates a well-defined, homogenous lesion with fat attenuation (-50 to -120 HU), characteristic of lipomas [7]. However, in emergency settings, as in our case, diagnosis is often made intraoperatively.

Surgical excision remains the mainstay of treatment. Depending on tumor size and involvement, local excision or segmental bowel resection may be performed [8]. Histopathological confirmation is essential to exclude liposarcoma. Prognosis after complete excision is excellent, with minimal recurrence risk [9].

CONCLUSION

Submucosal ileal lipoma is an uncommon cause of small bowel obstruction and should be considered in the differential diagnosis, particularly in young patients with no previous abdominal surgery. Early surgical intervention leads to rapid recovery and excellent prognosis.

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