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CASE REPORT

Rectal lipoma mimicking rectal prolapse: a case report and literature review

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ABSTRACT

Introduction: Rectal lipoma is an extremely rare benign neoplasm that can mimic rectal prolapse, accounting for only 3.4% of all colonic lipomas.
Case Report: A 69-year-old woman presented with an irreducible rectal prolapse. Evaluation revealed a multilobulated rectal lipoma measuring 8 × 8 cm. Transanal resection was performed, and histopathology confirmed the diagnosis.
Results: Postoperative recovery was uneventful, and the patient required no readmission.
Conclusion: Rectal lipomas are uncommon and may cause complications, such as necrosis or bleeding. Accurate diagnosis and timely surgical management are critical.

Keywords: *Lipoma; Rectal Neoplasm; Rectal prolapse; Colorectal surgery; Rectum*

INTRODUCTION

Hemorrhoidal prolapse and rectal prolapse are prevalent conditions with specific diagnostic and therapeutic approaches. Less frequently, other lesions such as rectal lipomas may also prolapse through the anus. In such cases, a high index of clinical suspicion is imperative to ensure appropriate management

Lipomas are benign soft tissue tumors composed of mature adipocytes. In 1957, Bauer first described this tumor in the gastrointestinal tract. Macroscopically and radiologically, lipomas are indistinguishable from normal adipose tissue; therefore, histopathological analysis remains the gold standard for diagnosis.

Colonic lipomas are relatively rare, with an incidence reported in the literature ranging from 0.035 to 4.4%,[1,2] with a predilection for involvement of the right colon. Rectal lipomas are even rarer, representing only 3.4% of all colonic lipomas.[3] They are more prevalent among adults between 40 and 59 years of age and exhibit a female predominance.[4] The aim of this publication is to report a case of a prolapsed rectal lipoma that mimicked rectal prolapse and to discuss the various entities that must be considered in the differential diagnosis.

CASE DESCRIPTION

A 69-year-old female patient presented to the emergency department with a 3-hour history of a clinical picture suggestive of an irreducible rectal prolapse unresponsive to digital reduction maneuvers (Fig. 1A). No associated symptoms or signs of ischemia or necrosis were observed; however, a short history of rectal bleeding was reported.

In this context, the patient was evaluated by a colorectal surgeon. Physical examination revealed a yellowish, indurated, friable, irreducible mass, without mucus or a central orifice, ruling out a lesion originating from the rectal mucosa (Fig. 1B). A digital rectal examination was performed, which revealed a thick pedicle originating from the muscular layer. The pedicle did not appear to infiltrate the anal sphincter. In light of these findings, surgical resection was deemed the optimal course of action.

A transanal approach was performed, revealing an 8 × 8 cm multilobulated tumor through the anal canal, with a single thick pedicle apparently arising from the muscular layer (Fig. 2A).

The utilization of a stapler for resection was deemed unfeasible, owing to the potential for iatrogenic rectal lumen occlusion. Consequently, throughout the procedure, the rectal lumen was stented using a catheter or a dissect-ing forceps, and the lesion was dissected by separating the mucosa from the rectal muscular layer until complete tumor resection was achieved (Figs. 2B and 2C).

Figure 1. *Rectal lipoma.* ***A.*** *Multilobulated, yellowish mass prolapsing through the anus, measuring approximately 8 × 8 cm.* ***B.*** *Identification of a pedicle not arising from the rectal mucosa.*

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Subsequently, the rectal mucosa was closed using interrupted 3-0 Vicryl sutures (Figure 2D).
The postoperative course was uneventful, and the patient was discharged on postoperative day five.

Histopathological examination revealed a benign neoplasm composed of mature adipocytes within a loose fibrovascular stroma, consistent with a lipoma (Fig. 3).

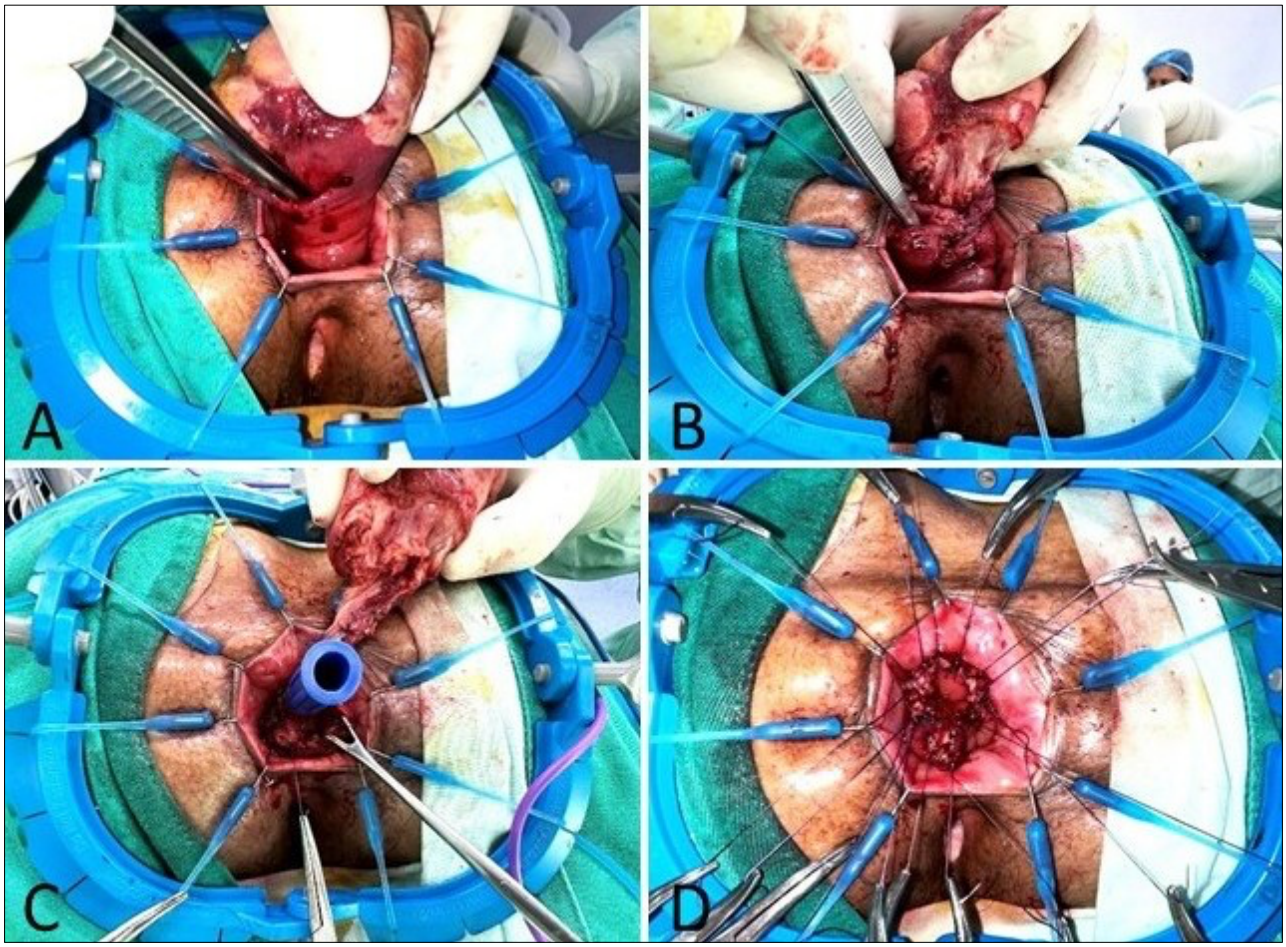

Figure 2. Transanal surgical excision of rectal lipoma. A. *Pedunculated lesion originating from the rectal muscularis propria* ***A.*** *dissecting forceps is visible within the rectal lumen.* ***B.*** *Dissection separating the rectal mucosa from the muscularis propria, with identification of the rectal lumen using a dissecting forceps.* ***C.*** *Stenting of the rectal lumen with a catheter to prevent luminal narrowing.* ***D.*** *Closure of the rectal mucosa following tumor excision.*

DISCUSSION

Colorectal lipomas are defined as benign non-epithelial tumors of mesenchymal origin with very low malignant potential. Histologically, they consist of spherical deposits of mature adipose tissue within the intestinal wall, surrounded by a fibrotic capsule. They are classified as submucosal, subserosal, intramuscular, or mixed types. The submucosal type is the most significant and prevalent pathological variant,[5] accounting for up to 90% of cases.[4],[6]
Macroscopically, these lesions are typically soft and well circumscribed, covered by normal-appearing mucosa, with a yellowish hue resulting from the underlying adipose tissue. They may be sessile or pedunculated and generally smaller than 2 cm.
Colonic lipomas are most commonly observed in the right colon, accounting for 65-75% of all cases.[7] Rectal involvement is exceedingly rare. A comprehensive 18-year analysis of 17 patients with colorectal lipomas revealed that only three cases of rectal lipoma were identified.[8] In another 10-year analysis conducted at the Mayo Clinic involving 91 patients with colorectal lipomas, no rectal lipomas were reported.[9] Prolapse of a rectal lipoma through the anus is an even rarer occurrence, with only a few cases reported in the literature and, to date, none reported in Colombia, making this clinical case particularly noteworthy.
Lipomas of the rectum or sigmoid colon may prolapse through the anus during defecation and may reduce spontaneously or with manual maneuvers. In some cases, acute irreducible prolapse may occur, as in our patient. The mucosa overlying the lipoma may show congestion and edema, focal erosion, or ulceration,[5] and may even act as a point of incarceration leading to ischemia and necrosis.[10]

Figure 3. Resected specimen. *Multilobulated yellow mass with a smooth cut surface.*

Differential diagnoses for lesions prolapsing through the anus should include mucosal or full-thickness rectal prolapse, hemorrhoidal prolapse, prolapsed rectal polyps, as well as other conditions including thrombosed hemorrhoids and the Buschke–Löwenstein tumor caused by human papillomavirus infection.
Colonoscopies are an essential diagnostic modality for the evaluation of colorectal lipomas. The majority of lipomas manifest as soft lesions

covered by smooth, normal-appearing mucosa, with an intact capsule. These lesions are mobile, deformable, and may be pedunculated or sessile. Occasionally, visible blood vessels are present. Despite the advent of several advanced endoscopic techniques, such as narrow-band imaging and in vivo cytological visualization methods like confocal laser endomicroscopy, which represent significant advances in diagnostic endoscopy, histopathological analysis remains the diagnostic gold standard. Additional diagnostic modalities include barium enema, endoscopic ultrasonography, abdominopelvic computed tomography, and magnetic resonance imaging.

Treatment of lipomas prolapsing through the anus is surgical, given their symptomatic presentation and the risk of complications such as ulceration, bleeding, and ischemia.

Li Jiang et al.[11] recommend surgical excision in the following situations: 1) lesions larger than 4 cm with a sessile morphology or a short pedicle; 2) uncertain preoperative diagnosis; 3) significant symptoms, particularly intussusception; 4) involvement of the muscularis propria or serosa; and 5) lesions not amenable to complete endoscopic resection.

CONCLUSION

Rectal lipomas prolapsing through the anus are rare and require prompt surgical management because of the risk of necrosis, ulceration, and bleeding. Awareness of the differential diagnoses of prolapsing anorectal lesions is essential, as these entities differ in diagnostic evaluation and therapeutic management.

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