Ulcerated Gastric Lipoma as a cause of Acute Gastrointestinal Bleeding
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Section: Abdominal imaging
Case Type: Clinical Cases
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Patient: 66 years, male

Clinical History:
Male Caucasian patient, with previous ischemic stroke, diabetes and high blood pressure presented to the emergency department with history of fluid black dejections and moderated abdominal pain. Submitted to Esophago-gastro-duodenoscopy followed by abdominal computed tomography (CT).

Imaging Findings:
A 66 year old male Caucasian patient with a background history of ischemic stroke, diabetes and high blood pressure presented to our department. He was medicated within others with aspirin 300 mg day and ranitidine. Presented to the emergency department with history of fluid black dejections and moderated abdominal pain without peritoneal reaction. He had normal blood pressure (130/84 mm Hg) and normal heart rate, and denied nausea, vomiting, reflux symptoms or haematemesis. Rectal inspection revealed dark faecal content. Blood tests revealed slight normocytic normocromic anaemia with haemoglobin of 11mg/dl and elevation of urea (83 mg/dl) without other relevant changes.

He was submitted to endovenous treatment with proton pump inhibitors, glucosal and polieletrolytic solutions followed by esophago-gastro-duodenoscopy. It revealed a elevated lesion in gastric antrum with peripheral normal mucosa and deep central ulceration (Fig 3) The Abdominal CT revealed a submucosal lesion (Fig 4a,b) measuring 52 x 27 mm with fatty density and irregular ulcerated central mucosa showing a little air inside (Fig.1,2), compatible with ulcerated gastric lipoma without signs of active bleeding. The patient was dismissed after 4 days.

Discussion:
Gastrointestinal bleedings are classified in high or down according to the location of the bleeding site: proximal or distal to the Treitz angle. High gastrointestinal bleeding may present as haematemesis or melaenas. The main cause is erosion or mucosal ulcer (55-77%), representing esophageal variceal, Mallory Weiss, vascular lesions and neoplasms the remaining causes by frequency order [1]. In cases of non massive suspect high gastrointestinal bleeding esophago-gastro-duodenoscopy is the first line examination [1]. Gastric tumours may be classified as benign or malignant. More than 95% of malignant tumours of the stomach are adenocarcinomas. Benign gastric tumours include smooth muscle and neural tumours, lipocytic tumours (e.g. lipoma, liposarcoma), tumours originating from vascular and perivascular tissues and gastrointestinal stromal tumours [2].

The majority [60-75%] of gastrointestinal lipomas are located in colon [2,3], followed by the small intestine [20-25%]. Gastric and duodenal lipomas are extremely rare accounting only for 5% of all gastrointestinal lipomas [3]. Lipomas are benign submucosal tumours composed of mature adipose tissue. They account for about 2-3% of benign gastric tumours and are usually detected incidentally. However, large lipomas (>3cm) [3,4] may have ulcerations as a result of pressure necrosis of the overlying mucosa and cause gastrointestinal bleeding. Large
lipomas can also cause intussusception or bowel obstruction. Lipomas tend to occur as solitary lesions, most frequently in the gastric antrum [3]. At CT, lipomas usually appear as a well-circumscribed submucosal mass with uniform fat attenuation. Therefore, a gastric lipoma can be definitively diagnosed with CT in most cases, and obviate the need of biopsy. However, if the tumour does not have 100% fatty density, biopsy is needed because it might not be a lipoma but a malignant neoplasm with fatty components [3,5]. Gastric lipomas have never been shown to have potential for malignant transformation [2]. The treatment of choice for a symptomatic gastric lipoma is circumferential excision with a clear margin of normal tissue [2].

**Differential Diagnosis List:** Ulcerated Gastric Lipoma as a cause of Acute Gastrointestinal Bleeding

**Final Diagnosis:** Ulcerated Gastric Lipoma as a cause of Acute Gastrointestinal Bleeding

**References:**


Description: Fatty submucosal lesion in gastric antrum - 52 x 27 mm Origin:
**Figure 2**

*Description:* Submucosal lesion with fatty density and irregular ulcerated central mucosa showing a little air inside, compatible with ulcerated gastric lipoma. *Origin:*
Figure 3

Description: Elevated lesion in gastric antrum with peripheric normal mucosa and deep central ulceration. Origin:
Description: Elevated submucosal lesion Origin: