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Case Report

Genital prolapse with rectal lipoma: a case report and literature review

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ABSTRACT

A postmenopausal woman presented with mass prolapsing per vagina, hematochezia, tenesmus constipation and loss of appetite of six months duration. Speculum examination showed second degree uterovaginal prolapse, cystocele and rectocele. Vaginal examination showed uterus atrophic retroverted and fornices free. Rectal examination revealed a soft smooth swelling in the anterior wall of rectum. Contrast enhanced CT scan of the abdomen revealed rectal submucosal lipoma. She underwent vaginal hysterectomy with pelvic floor repair and transanal delivery of the rectal lipoma.

Keywords: Genital prolapse, Lipoma, Rectum, Transanal excision, Hematochezia

CASE REPORT

A 58-year-old postmenopausal woman presented with mass prolapsing per vagina hematochezia, tenesmus, constipation and loss of appetite of six months duration. On general examination patient was thin built with pallor. Abdominal examination was unremarkable. Speculum examination showed second degree uterovaginal prolapse, cystocele and rectocele. Vaginal examination showed uterus atrophic retroverted and fornices free. Recto vaginal examination showed mass in rectum/rectovaginal septum with atrophic perineal body per rectal examination revealed a soft swelling in the anterior wall of rectum measuring approximately 3x3 cm, 6 cm above the anal verge, with smooth surface and the overlying mucosa was free. She underwent colonoscopy which showed a submucous mass in the rectum of size 3 cm x 3 cm at about 6 cm from the anal verge. Contrast enhanced CT scan of the abdomen revealed rectal submucosal soft tissue mass suggestive of lipoma of size 3 cm x 3 cm (Figure 1). She underwent vaginal hysterectomy with pelvic floor repair. This was followed by transanal delivery of the rectal lipoma (Figure 2). Overlying mucosa was incised and lipoma was excised. The macroscopic appearance was suggestive of lipoma. Histological examination confirmed the diagnosis of lipoma.

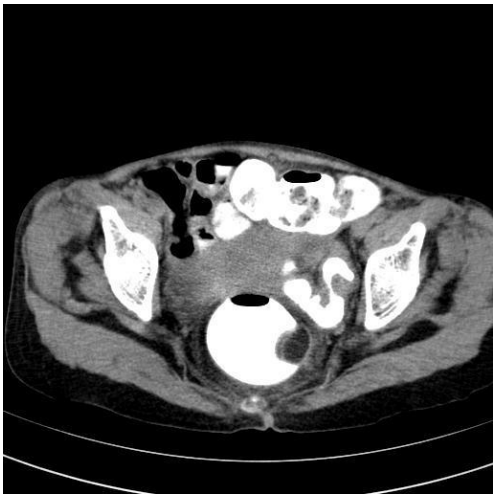

Figure 1: Contrast enhanced CT scan abdomen.

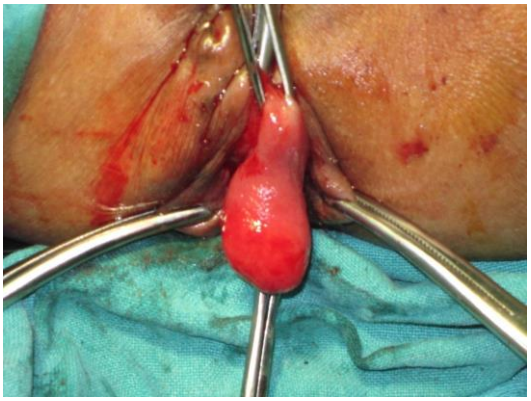

Figure 2: Intraoperative picture showing prolapsed rectal lipoma.

DISCUSSION

Genital prolapse although common its occurrence with rectal lipoma is very rare. Lipoma of the gastrointestinal tract was first described by Bauer et al.[1] Lipomas of the large intestine are relatively uncommon in clinical practice. Most of them are incidentally detected during a routine endoscopic examination. Usual occurrence in sixth decade of life with an incidence of 0.2% to 4.4%.[2] Some authors have reported a female predominance while others found a nearly equal sex incidence. The most common site of origin is the right colon.[2] There is no explanation for the predilection of lipomas of the large bowel to occur in the right side. Lipomas of the rectum are quite rare, and in various studies only a few cases are reported. In the series of Castro and Stearns 2, only 5 out of 45 lipomas of the large bowel (11.1%) were in the rectum and only one of these was palpable. The size of the lipomas of the rectum was recorded in 4 cases: 3 were less than 2 cm, and one was 2-4 cm in diameter. Lesions are sessile or polypoid and are submucosal, in about 90% of cases. Vast majority are asymptomatic but manifest with intussusception, ulceration leading to hemorrhage, intestinal obstruction, prolapse and rectal bleeding. Lipomas of size greater than 2 cm cause symptoms such as constipation, diarrhea, abdominal pain. Our case presented with rectal bleeding and partial rectal prolapse. Spontaneous expulsion of a sigmoid lipoma has been reported. The prolapse of a rectal lipoma through the anus is a rare event, and a few cases are reported in the literature.[3] One of the greatest clinical significance of lipoma is its potential to be confused with colonic malignancy because of its similarity in symptomatology. Diagnostic approach usually includes endoscopy, contrast enhanced scan of the abdomen and barium enema. Endoscopic biopsies are usually negative as the lipomas are situated below the normal mucosa. Management depends on the location and presentation of the lipoma.

Endoscopic removal has been reported for lipomas upto a size of 2 cm however larger lesions carries the risk of haemorrhage and perforation.[1] Surgical procedures include laparotomy enucleation, colostomy and excision of lipoma, segmental colonic resection. In case of rectal lipomas, transanal excision can be done for lower third lesions. Gastrointestinal lipomas are rare and pose a diagnostic challenge. Endoscopy shows a submucous swelling and helps to rule out other lesions. Imaging reveals tissue with signal intensity and uptake of adipose tissue. Endoscopic removal can be attempted for a size of upto 2 cm but the complication includes hemorrhage, perforation and obstruction. Laparoscopic or open resection may be required in lipomas of more than 2 cm. In case of rectal lipomas transanal excision can be attempted.

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