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### Endoscopic removal of giant colonic lipomas

Although usually asymptomatic, large lipomas (>2 cm) of the large bowel may occasionally present with bleeding, abdominal colicky pain, obstruction and intussusception. Because a majority of them are submucosal, endoscopic removal entails high risk of perforation, since the high water content requires a tremendous amount of heat to cut through. We describe our experience in endoscopic removal of giant (>2 cm) colonic lipomas in 6 patients with associated symptoms (Table).

The base of each lesion was injected with saline solution or a 1:10,000 solution of epinephrine (5-10 mL), and the lesion was then removed by monopolar electrosurgical snare resection. A large hexagonal snare (Olympus; Tokyo, Japan) was needed to ensnare the lesion near its base. In one patient (case 6), complete excision of the lesion could not be performed despite use of an excessive amount of monopolar current. The snare was removed from around the base of the lesion without difficulty. On the 12th day after attempted endoscopic removal, the patient reporting defecation of

**Table: Patient characteristics**

No	Dimension of polyp (cm)	Stalk (length x diameter)	Clinical presentation
1	2.3 x 2.5	No stalk	Rectal bleeding
2	4.0 x 2.5	1.0 x 0.5	Rectal bleeding
3	2.5 x 2.5	1.5 x 1.0	Massive hemorrhage
4	2.7 x 2.5	No stalk	Rectal bleeding
5	3.5 x 2.8	No stalk	Abdominal pain
6	4.4 x 4.0	1.0 x 2.0	Intussusception



**Fig: Large crater at site of auto-amputated lipoma**

the polypoid mass. No complications were noted. All, except one, patients were discharged one hour after the procedure. On histologic examination, the resection specimens were submucosal lipomas; none of the specimens contained muscularis propria.

Follow-up endoscopy was performed at 3 months. In case 6, a large crater 4 cm in diameter (Fig) with residual adipose tissue in the margins was seen at the site of the resected lipoma. Follow-up sigmoidoscopy 11 months later was normal.

Colonoscopic polypectomy of large lipoma is difficult although possible in selected cases (especially if pedunculated). Various techniques (submucosal saline injection, endoscopic ultrasound)<sup>1,2</sup> have been advocated to reduce the reported high risk of perforation.<sup>3</sup> We did not perform endoscopic ultrasound before excision but we injected saline submucosally to create a protective cushion of fluid within the colonic wall. Removal of pedunculated lipomas does not provide any increased risk as compared with the removal of pedunculated adenomatous polyp.<sup>4</sup>

To our knowledge, this is the first report of lipoma expulsion in feces subsequent to failure of endoscopic removal. Raju *et al*<sup>5</sup> reported placement of a detachable nylon loop in the stalk of a large lipoma that was left in place; the lipoma regressed progressively, probably due to ischemia.

Georgia Lazaraki, Dimitrios Tragiannidis,  
Anestis Tarpagos, Dimitrios Tzilves,  
Ioannis Pilpilidis, Ioannis Katsos

Department of Gastrointestinal Oncology, Theagenion  
Cancer Hospital, Thessaloniki, Greece

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**Correspondence to: Dr Lazaraki, Gastroenterologist, Papadaki  
14 str, 54248 Thessaloniki, Greece. Fax:: 30 (23) 1089 8408. E-mail: lazarakg@yahoo.com**