



## Endoscopic resection of symptomatic simultaneous angiolipoma of the colon and duodenum: First case report and literature review

To the Editor,

A 67-year-old male visited with complaints of lower abdominal pain, indigestion, and decreased stool caliber for several months. On total colonoscopy, a round, yellowish, smooth mass-like lesion was noted in the sigmoid colon. Its consistency was soft and collapsed by endoscopic forceps. Esophagogastroduodenoscopy (EGD) revealed an elongated mass-like lesion in the second portion of the duodenum with a similar nature. On computed tomography (CT) scan, both masses were seen as well-defined 2-cm-sized lesions, including fat density.

An endoscopic intervention of the two lesions was performed for removal. The colonic lesion was managed first (Figure 1a-d); a detachable snare was first applied on the polypoid mass, and a conventional snare was guillotined slightly above it. An EGD was performed to resect the duodenal lesion with a conventional snare (Figure 1e, f). Transient bleeding occurred shortly after resection, but hemostasis was achieved after several clips. Histological examination revealed a demarcated submucosal lesion consisting of mature adipose tissue admixed with a vascular capillary organization. The resection margin was free of tumors. No post-removal bleeding was noted, and the patient is currently being followed up for more than 1 year with no apparent complication or symptom recurrence.

Angiolipoma is a benign hamartoma, composed of mature fat cells admixed with a vascular component. This disease is commonly discovered on subcutaneous adipose tissue of the trunk and arms. Angiolipoma in the gastrointestinal (GI) tract is a rare entity, with only a handful of sporadic reports. Clinical symptoms and signs diverge, from asymptomatic cases to acute or chronic GI bleeding, abdominal pain, intus-



**Figure 1. a-f.** Endoscopic removal of gastrointestinal angiolipoma. A pedunculated polypoid mass was noted in the sigmoid colon (a), and a detachable snare was first applied on the mass (b). Thereafter, snare polypectomy was done with a conventional snare (c), leaving a short stalk of normal tissue (d). Another angiolipoma in the duodenum (e) was similarly removed using a conventional gastroscope and snare. Endoclips were applied on the stump of the resected tumor in case of post-procedural hemorrhage (f).

susceptions, and so on. On CT, angiolipomas have a low-density region that is suggestive of fat tissue. Lesions vary in gross morphology, showing sessile or pedunculated shapes. Histologically, angiolipomas consist of mature adipocytes along with vascular components.

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**Received:** 14.1.2013 **Accepted:** 5.8.2013

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Gastrointestinal angioliipomas are recently being more recognized than previously acknowledged, thanks to the wide dissemination of endoscopy. According to a recent literature review, only 17 cases have been discovered worldwide (1). Our case is a rarer exemplification of synchronous (duodenal and colonic) angioliipomas that were both successfully removed by an endoscopic method. One report described a concurrent GI angioliipoma, with no thorough explanation (2). Upon our literature search, four more cases were reported in addition to the previous literature review, and their distribution of tumors was as follows: ileum 2 (3,4), colon 1 (5), and rectum 1. Previously reported cases were mostly managed via surgery. Surgical resection is preferred to endoscopic resection, especially broad-based or pedunculated large polyps, because of the risk of perforation and bleeding. However, endoscopic removal has been replacing invasive surgery lately.

**Ethics Committee Approval:** N/A.

**Informed Consent:** N/A.

**Peer-review:** Externally peer-reviewed.

**Author contributions:** Concept - S.P., H.J.C.; Design - S.P., W.J.L., H.J.C.S.; Resource - H.J.C.; Materials - H.J.C.; Data Collection&/or Processing - S.P., W.J.L.; Analysis&/or Interpretation - S.P., H.J.C.; Writing - S.P.; Critical Reviews - E.S.K., B.K., Y.S.S., Y.T.J., H.S.L., S.H.U., C.D.K., H.S.R., H.J.C.

**Conflict of Interest:** No conflict of interest was declared by the authors.

## Park et al. Endoscopic resection of dual GI angioliipoma

**Financial Disclosure:** The authors declared that this study has received no financial support.

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