
CASE REPORT**Ileal lipoma leading to chronic non-obstructing ileo-ileal intussusception in an adult***Abhijit Rayate^{1*}, Apurv Butiyani¹, Akshar Saraswat¹, Bhaskar Kendre¹**¹Department of Surgery, M.I.M.S.R. Medical College, Latur-413512 (Maharashtra), India*

Abstract

Intussusception is uncommon in adults and usually secondary to malignant lesion. Apart from nonspecific abdominal symptoms or gastrointestinal bleeding, ileal lipomas can present with intussusception with obstruction. Ileo-ileal intussusception is rare and those due to ileal lipomas are even rarer. Computed tomography scan is diagnostic for both intussusception and ileal lipomas. Patients with intussusception due to ileal lipomas usually present acutely with short history. Chronic history with insignificant symptoms is rare presentation. We report a case of 35-years-old man who presented with chronic non-obstructing ileo-ileal intussusception with pedunculated ileal lipoma (5cm size) as lead point. We managed the case with laparoscopic reduction of the intussusception with extracorporeal segmental resection and side to side anastomosis in a rural setup. Histology confirmed an encapsulated lipoma submucosally. Radiologic assessment and minimally invasive techniques jointly achieved definitive diagnosis (benign etiology) and treatment (preserving bowel and minimizing morbidity due to formal laparotomy).

Keywords: Chronic, Ileal lipoma, Ileo-ileal, Intussusception, Laparoscopic reduction

Introduction

Intussusceptions are usually seen in children and mostly due to benign aetiology. Most of adult intussusceptions usually are secondary to malignancies.[1] In many cases, malignant lesions may be mistaken for intussusception. Adult patients of intussusception mostly present as acute bowel obstruction [1,2]. Chronic intussusception without obstruction is quite rare and is usually due to small lesions. Literature reports that among the intussusceptions due to ileal lipomas, most are of ileo-colic type. We report a case of pedunculated ileal lipoma (5 cm size) causing chronic non-obstructing ileo-ileal intussusception in an adult. We managed the case with laparoscopic reduction of the intussusception with extracorporeal segmental resection and side-to-side anastomosis in a rural setup.

Case Report

A 35-year-old man had presented with chronic (past 10-12 months) non-specific abdominal symptoms of intermittent colicky pain without vomiting. The pain was mild in nature and mostly in lower abdomen without any diurnal variations, aggravating or relieving factors. Appetite and bowel habits were normal. He had no co-morbidities or addictions. Per abdominal exam was essentially normal. Sonography revealed a target lesion mass suggestive of intussusception. Contrast enhanced Computerized Tomography (CT) of abdomen revealed “target sign” lesion and telescoping of bowel involving distal ileal loops and without features of obstruction. Intraluminal low-density well-defined lesion was suggestive of lipoma as lead point (Figure 1).

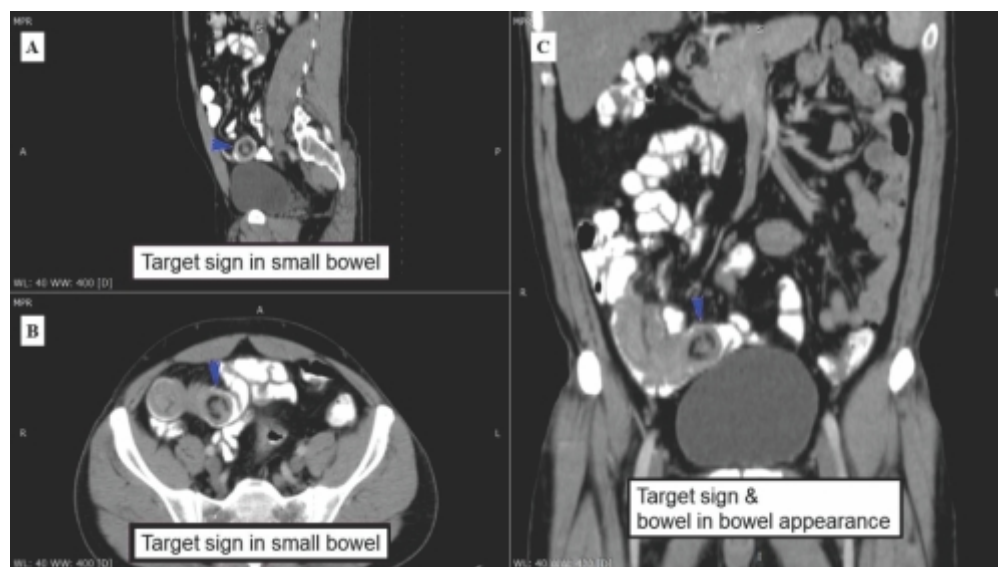


Figure 1: Contrast enhanced computed tomography of abdomen showing the target sign (blue arrow) in sagittal (A) and transverse (B) sections and along with telescoping segments in coronal section (C). The lead-point lesion has low-attenuation fat-density feature.

On diagnostic laparoscopy, a non-obstructing ileo-ileal intussusception was evident (Figure 2A). The globular yet mobile lesion (Figure 2B) could be appreciated. Proximal loop was gently reduced (Figure 2C and D). Due to dense adhesions and local oedema, the last few centimetres could not be reduced hence we decided to place a 5cm infraumbilical midline incision. Since the benign aetiology was already defined on CT, an extracorporeal anastomosis was done in

standard fashion after segmental resection of affected ileum. On opening the specimen, a pedunculated soft ileal lipoma of 5 cm (Figure 2E and F) was noted and was confirmed on histopathological examination. Post-operative period was uneventful and patient was discharged on the fifth day. The patient had duly consented for use of operative images and reports for this publication. We have maintained confidentiality throughout the process.

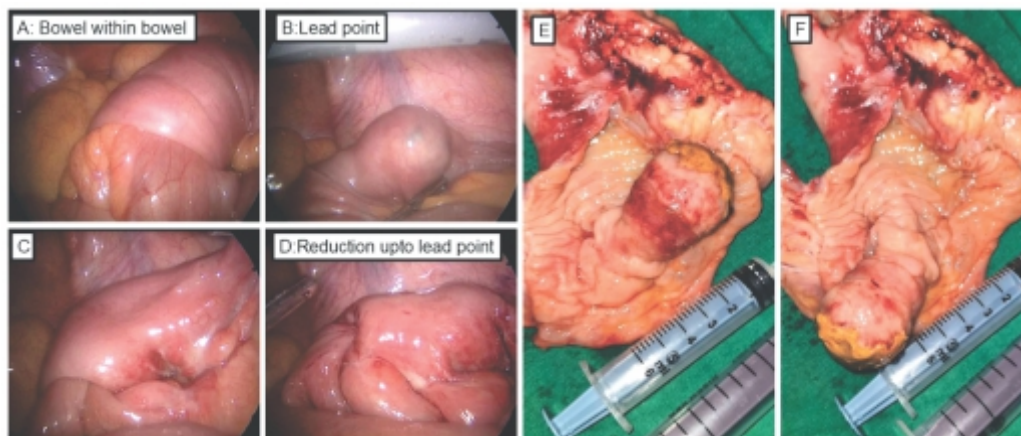


Figure 2: A non-obstructing ileo-ileal intussusception (A) with globular yet mobile lead point (B). Proximal loop was gently reduced up to the lead point (Figure 2C and D); local oedema and adhesions are evident. Cut sections of the resected bowel showing a pedunculated soft ileal lipoma of 5 cm (Figure 2E and F)

Discussion

Adult intussusception is an uncommon clinical entity and differs markedly from the paediatric condition in aetiology and management. Unlike paediatric cases, adult intussusception frequently has an identifiable organic lesion (> 90%), with benign lesions (lipomas, polyps, adenomas) accounting for a significant proportion, especially in small bowel intussusceptions in reported series [1-4]. Adult ileo-ileal intussusception is rare and usually presents as nonspecific, chronic or subacute symptoms such as nausea, intermittent abdominal pain, vomiting, and sometimes anaemia or GI bleeding [1,4].

Small-bowel lipomas are a less common but well-recognized benign cause of intussusception in adults [1,4]. Lipomas large enough to cause intussusception, are typically pedunculated as in our case, and may reach several centimetres before becoming symptomatic. Case series and reports document presentations ranging from acute obstruction to chronic intermittent pain depending on mobility and degree of luminal compromise [5-9].

Contrast-enhanced CT is central to preoperative planning because it can both confirm the diagnosis and often suggest the nature of the lesion. Intestinal lipomas are well-circumscribed, low-attenuation and intraluminal masses, consistent with fat density [1,2,8]. In our patient, the CT appearance of a low-density intraluminal lesion correctly suggested a lipoma (benign aetiology) and helped us plan a minimally invasive strategy.

Unlike children, up to two-thirds of adult cases have an identifiable pathological lead point of neoplastic aetiology, which has historically driven a low threshold for resection rather than reduction [2,3,9,10]. However, when preoperative imaging and intraoperative findings suggest a benign aetiology—particularly in small-bowel intussusceptions—selective reduction followed by limited resection can preserve bowel length and reduce morbidity [1-3]. Laparoscopy has emerged as a feasible approach for both diagnosis and treatment, offering the advantages of inspection, gentle

reduction, resection and anastomosis, as well as extracorporeal resection through a small incision if necessary [1,2,4]. Laparoscopic management in such cases may need conversion to open procedure due to adhesions, bowel oedema, or technical difficulties [1,4]. The combination of laparoscopic reduction and extracorporeal anastomosis represents a practical approach while working within the constraints of available infrastructure and expertise and choice of anastomosis depending on bowel status [6,8].

This case underscores several practical points. First, CT features of fat attenuation within an intussuscepted segment are usually diagnostic for lipoma and may justify a conservative resection strategy.

Second, chronic, non-obstructing presentations warrant cross-sectional imaging to avoid delayed diagnosis. Third, laparoscopy with selective reduction and extracorporeal resection is a safe, bowel-sparing option even in non-tertiary settings when imaging suggests benign pathology and intraoperative assessment confirms mobility and lack of ischemia [1,10].

Conclusion

This report adds to the literature supporting individualized management of adult small-bowel intussusception: careful radiologic assessment and minimally invasive techniques, to achieve definitive treatment while preserving bowel and minimizing morbidity when a benign lesion is likely.

References

1. Heersche S, Hirt J, Butti F, Hübner M, Hahnloser D, Joliat GR, *et al.* Intestinal intussusception in adults: A systematic review. *World J Surg* 2025; 49(10):2706-2716.
2. Al-Radaideh AM, Omari HZ, Bani-Hani KE. Adult intussusception: A 14-year retrospective study of clinical assessment and computed tomography diagnosis. *Acta Gastroenterol Belg* 2018; 81(3):367-372.
3. Attoun MA, Albalawi SMD, Ayoub A, Alnasser AK, Alkaram EH, Khubrani FA, *et al.* The management of intussusception: A systematic review. *Cureus* 2023; 15(11): e49481.
4. Farkas N, Wong J, Bethel J, Monib S, Frampton A, Thomson S. A systematic review of symptomatic small bowel lipomas of the jejunum and ileum. *Ann Med Surg (Lond)* 2020; 58:52-67.
5. Viveki PR, Hukkeri VB. Small intestinal multiple lipomatous polyps: A cadaveric case report. *J Krishna Inst Med Sci Univ* 2013; 2(2): 134–137.
6. Alhammad F, Prakash A, Alhashimi FM, Jaffar M, Ikram F, AlBastaki S. From an incidental lipoma to ileo-ileal intussusception in an adult: A case report. *Int J Surg Case Rep* 2024; 123:110164.
7. Wang Y, Liu Y, Fan H, Liang W. Ileal lipoma causing intussusception and intestinal obstruction in an adult: A case report. *Asian J Surg* 2025; 48:1538-1539
8. Hu Q, Wu J, Sun Y. Intussusception related to small intestinal lipomas: A case report and review of the literature. *Front Surg* 2022; 9:915114.
9. Alam F, Chikukuza S, Okkeh O, Tsvetkov F, Hanif Z, Lawrence J, *et al.* Small bowel lipoma and intussusception: a case report. *J Surg Case Rep* 2024; 2024(5): rjae327.
10. Panzera F, Di Venere B, Rizzi M, Biscaglia A, Praticò CA, Nasti G, *et al.* Bowel intussusception in adult: Prevalence, diagnostic tools and therapy. *World J Methodol* 2021; 11(3):81-87.

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