Gastric Lipoma Presenting with Dyspepsia
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Abstract
Gastric lipoma is one of the rare benign gastric tumors. Its preoperative diagnosis obviates the need of an extended gastrectomy. We report a case of gastric lipoma who presented with symptoms of dyspepsia and was treated by surgical gastrectomy and tumour enucleation.

INTRODUCTION
Lipomas are slow growing benign tumours of the gastrointestinal tract.1 Their common site is colon. They account for only 3% of benign gastric tumours.1 Gastric lipomas may remain asymptomatic, or can present with hemorrhage, obstruction or dyspepsia.2

CASE REPORT
A 65 year old male presented with history of dull aching pain in upper abdomen along with early satiety of four months duration. There was no history of hematemesis, melena, vomiting or weight loss. He had no past history of any chronic illness. He was not a known alcoholic or smoker and there was no history of any drug ingestion.

On physical examination, there was no abdominal mass, tenderness or signs of gastric outlet obstruction. On laboratory investigation, his haemogram, liver function and renal function tests were within normal limit.

Upper gastrointestinal endoscopy revealed a mass of about 5 cm diameter in the lesser curvature of stomach above the incisura. It had a necrotic polypoidal base with central ulceration (Fig. 1). Biopsy of the lesion revealed yellow, cheesy material. Histology of endoscopic biopsy was suggestive of a submucosal gastric lipoma. CT scan of abdomen revealed a low attenuation rounded fairly well defined soft tissue mass measuring 5 x 6 cm in diameter.

With the diagnosis of a giant ulcerated gastric lipoma the patient was subjected to surgery. Gastrotomy was done, ulcer crater was excised and the lipoma was enucleated. The procedure was uneventful and on follow up the patient was symptom-free.

The histopathological examination of a resected specimen revealed ulcerated, inflamed gastric mucosa covered with an exudate. The submucosa was very vascularized. On the deeper sections was seen a tumour comprised of sheets of mature adipocytes; at places proliferating vascular channels were seen surrounded by collars of proliferating smooth muscles. With these findings the final diagnosis of gastric lipoma was established.

DISCUSSION
Lipomas are benign tumours. They occur commonly in subcutaneous tissues. Gastric lipomas are mostly
submucosal in origin (90%); and 75% occur in the antrum. Small gastric lipomas remain asymptomatic, but lipomas of more than 4 cm in diameter become symptomatic. Bleeding due to pressure necrosis of the overlying mucosa can lead to ulceration and chronic blood loss. Sometimes it may present with massive GI hemorrhage. Other clinical presentations are due to its antral location, where it prolapses into pylorus leading to obstructive or dyspeptic symptoms. Due to extreme softness of these tumors, they can change their shape and remain latent for a long period.

Diagnosis of lipoma is important as these are benign tumors and their removal should result in complete relief in symptoms. Upper gastrointestinal endoscopy helps in diagnosis by following characteristics; “tenting sign”, i.e. the mucosa can be pulled from the lesion by biopsy forceps, “naked fat sign” i.e. fat protrudes from the mass when biopsies are taken, and “cushion sign” where an impression is left on the mass, when a forceps is advanced into the mass.

CT scan has a role in diagnosis as it gives information about the size, location and relation to other closeby viscera. Lipomas are seen as low attenuating homogenous masses on CT scans. Primary GI liposarcoma, on the other hand appear inhomogenous and have higher attenuation. Endoscopic ultrasound can help in diagnosing the submucosal lesion as also in its endoscopic treatment.

Surgical resection is the mainstay of treatment. It can be treated with simple local enucleation or partial gastric resection. Endoscopic snare removal of a submucosal lipoma is another option for small submucosal lipomas. However laparoscopic removal of large gastric lipoma has been successfully performed and offers advantage over an open surgery.

REFERENCES