



Large Pelvic Lipoma Causing Femoral Hernia

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Abstract

Case Report: A 73-year-old lady presenting with a three-day history of a constipation, vomiting and abdominal pain.

Diagnosis: On examination, a right femoral hernia was identified and this was confirmed on CT imaging with evidence of mechanical small bowel obstruction. There was an incidental finding of a large pelvic lipoma causing mass effect.

Treatment: This lady underwent open repair of the femoral hernia.

Discussion: Intra-abdominal lipomatosis is a rare finding and can present itself in a variety of manifestations, or, can be identified as an incidental finding on cross-sectional imaging. Bowel obstructions, abdominal pain, lipoma and abdominopelvic hernias are some examples of symptomatic presentations of intra-abdominal lipomas.

Introduction

A lipoma can be defined as one of the most common mesenchymal tumors found in the body composed of adipose cells, frequently surrounded by a thin layer of fibrous tissue. They may arise from any location of the body where adipose tissue is typically present, usually within the subcutaneous tissues of the neck, back, abdomen or thighs [1]. The exact incidence and prevalence of intra-abdominal lipomatosis is unclear but upon review of the literature, it seems there are greater than 50 case reports published to date [2]. In some cases, there is an underlying disorder such as proteus syndrome, benign symmetrical lipomatosis (aka Madelung's disease) or macrodystrophia lipomatosa associated with these presentations however, many are asymptomatic in nature and represent incidental findings on cross-sectional imaging [3,4].

Case Presentation

A 73-year-old female presented to the emergency department with a three-day history of constipation associated with a two-day history of abdominal pain, vomiting and an inability to tolerate oral intake. She had no significant background medical history. The pain was located in the right lower quadrant, constant, non-radiating and described as colicky in nature. Physical examination yielded a distended and tender abdomen. More notably, a palpable and irreducible right femoral hernia measuring 3 cm × 3 cm was located. A diagnosis of small bowel obstruction secondary to a femoral hernia was formulated, indicated by plain film abdomen, and confirmed by Computerized Tomography Abdomen and Pelvis (CTAP) with contrast.

The CTAP revealed evidence of mechanical small bowel obstruction with the transitional zone located at the level of the strangulated right femoral hernia. Incidentally, a large lipoma in the left side of the pelvis was observed creating a mass effect and shifting abdominal viscera toward the right side of the pelvis (Figures 1-3).

An open right femoral hernia repair was performed under general anesthetic which revealed findings of an incarcerated femoral hernia. Small bowel reperfusion was accomplished with application of warm moist swabs, 100% high flow oxygen and no resection was required. An anatomical repair was performed and the patient recovered well in the postoperative period.

An MRI was performed to further evaluate the lesion which illustrated pelvic lipomatosis measuring 9.4 cm × 11 cm × 14 cm predominantly within the posterior and left side of the hemipelvis with displacement of pelvic organs and large and small bowel anteriorly and to the right. There were no suspicious features identified. The patient was referred to a specialist center for further evaluation but refused biopsy of the lesion (Figure 4).

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Figure 1: Axial view right femoral hernia on CT AP.

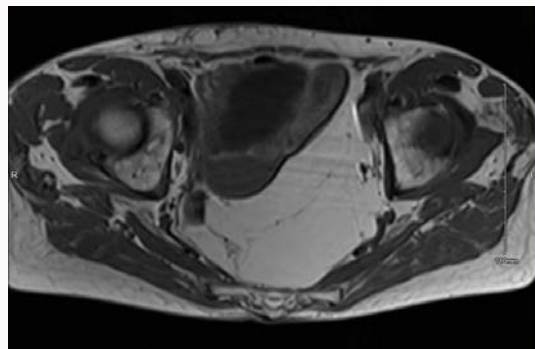


Figure 4: Axial view of pelvic lipoma on MRI.

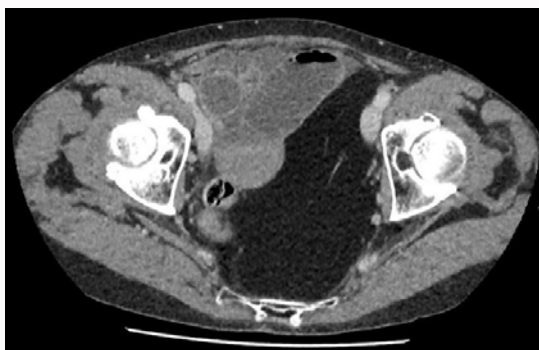


Figure 2: Axial view left-posterior intra-pelvic lipoma on CT AP.

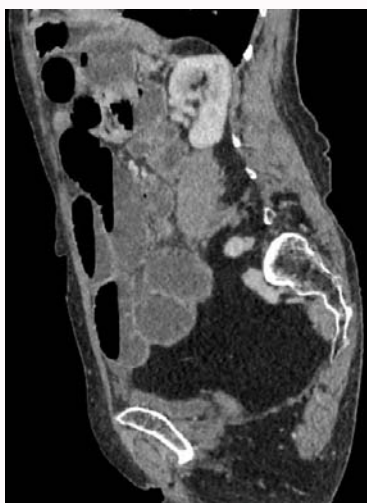


Figure 3: Sagittal view of intra-pelvic lipoma with evidence of small bowel obstruction also seen.

Discussion

There are a variety of cases reported in the literature with regards to intra-abdominal lipomas. One such category is that of severe abdominal pain related to torsion of lipomas related to the sigmoid colon and torsion of a pedunculated lipoma arising from the abdominal wall overlying the right iliac fossa mimicking acute appendicitis [5]. Another clinical presentation associated with these large intra-abdominal lipomas was symptoms of intestinal obstruction [6].

There is limited number of case reports in the literature relating to hernias caused secondary to intra-abdominal lipomatosis. Three of those described include a case of a hernia sac containing the uterus associated with a large intra-abdominal lipoma, a sliding indirect lipomatous hernia without a hernial sac and a sciatic hernia composed of lipomatous mass transverse the greater sciatic foramen [7-9].

Femoral hernias are less commonly identified in the general population and equate to fewer than 4% of all hernias and there was no case described in the literature pertaining to a femoral hernia in the context of a large intra-abdominal lipoma [10]. This case depicts a unique presentation of intra-abdominal lipoma exerting a pressure effect on the viscera and leading to the development of an incarcerated femoral hernia. It illustrates the benefits of preoperative imaging to confirm diagnosis of clinical diagnosis and elucidate cause for same.

References

1. Charifa A, Azmat CE, Badri T. Lipoma Pathology: StatPearls Publishing, Treasure Island (FL); 2022.
2. Cha JM, Lee JI, Joo KR, Choe JW, Jung SW, Shin HP, et al. Giant mesenteric lipoma as an unusual cause of abdominal pain: A case report and a review of the literature. *J Korean Med Sci.* 2009;24(2):333-6.
3. Furquim I, Honjo R, Bae R, Andrade W, Santos M, Tannuri U, et al. Proteus syndrome: Report of a case with recurrent abdominal lipomatosis. *J Pediatr Surg.* 2009;44(4):e1-e3.
4. Fritz TR, Swischuk LE. Macrodystrophia lipomatosa extending into the upper abdomen. *Pediatr Radiol.* 2007;37(12):1275-7.
5. Sathyakrishna BR, Boggaram SG, Jannu NR. Twisting lipoma presenting as appendicitis-A rare presentation. *J Clin Diagn Res.* 2014;8(8):ND07-8.
6. Walker BS, Davis JL, Mayo SC. Large pancreatic lipoma causing duodenal obstruction. *J Gastrointest Surg.* 2021;25(4):1070-2.
7. Turk E, Karagulle E, Oguz H, Toprak E. Indirect hernial sac containing the uterus, ovary, and fallopian tube in association with a giant intraabdominal lipoma: Report of a case. *Hernia.* 2012;16(5):593-5.
8. Lau H. Sliding lipoma: An indirect inguinal hernia without a peritoneal sac. *J Laparoendosc Adv Surg Tech A.* 2004;14(1):57-9.
9. Skipworth RJ, Smith GH, Stewart KJ, Anderson DN. The tip of the iceberg: A giant pelvic atypical lipoma presenting as a sciatic hernia. *World J Surg Oncol.* 2006;4:33.
10. Pillay Y. Laparoscopic repair of an incarcerated femoral hernia. *Int J Surg Case Rep.* 2015;17:85-8.