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Synchronous mid-descending colon cancer and jejunal intraluminal lipomas presenting as intussusception: A rare case report

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Abstract
Background: Adult intussusception is rare and typically associated with an underlying lesion acting as a lead point. Jejunal lipomas, though benign, can occasionally cause such findings. The synchronous occurrence of a descending colon carcinoma and jejunal lipoma-induced intussusception is extremely uncommon and often detected incidentally.
Case Presentation: A 62-year-old male was evaluated for intermittent abdominal pain with history of few episodes of per rectal bleed. Contrast-enhanced computed tomography (CT) revealed a mid-descending colon mass suggestive of carcinoma, along with a coincidental finding of small bowel intussusception. The patient underwent exploratory laparotomy, which confirmed a mid-descending colon tumour and jejuno-jejunal intussusception caused by multiple intraluminal jejunal lipomas. A left hemicolectomy and segmental jejunal resection with primary anastomoses were performed.
Conclusion: This case highlights an unusual synchronous presentation of colorectal malignancy and incidental jejunal intussusception due to lipomas. Such findings underscore the value of detailed preoperative imaging and thorough intraoperative assessment, even in the absence of overt obstructive symptoms.

Keywords: Adult intussusception, jejunal lipoma, descending colon carcinoma, incidental finding, synchronous pathology, left hemicolectomy

Introduction
Intussusception in adults is an uncommon clinical entity, accounting for approximately 5% of all intussusception cases and only 1-5% of intestinal obstructions in adults. Unlike paediatric cases, where intussusception is typically idiopathic, adult intussusception is usually secondary to an identifiable pathological lead point, such as benign or malignant tumours, polyps, or Meckel's diverticulum. Among benign lesions, lipomas of the small intestine are rare, slow-growing tumours that may remain asymptomatic or, occasionally, cause intermittent abdominal symptoms or serve as lead points for intussusception.
Colorectal carcinoma remains one of the most common gastrointestinal malignancies worldwide. However, the synchronous occurrence of a colonic adenocarcinoma with an incidental, asymptomatic intussusception due to jejunal lipomas is extremely rare. Such cases pose diagnostic and intraoperative challenges, particularly when imaging findings may not correlate with classical clinical symptoms.
We report a rare case of a 62-year-old male with a mid-descending colon carcinoma, in whom a coincidental jejuno-jejunal intussusception due to intraluminal lipomas was identified on preoperative imaging and confirmed intraoperatively. To our knowledge, very few reports exist describing this unique dual pathology. This case emphasizes the importance of comprehensive imaging and intraoperative assessment in identifying synchronous gastrointestinal pathologies that may impact surgical decision-making.

Case History
Patient is a 62-year-old male brought by relatives to the surgery OPD with complaints of intermittent abdominal pain and few episodes of per rectal bleed since last 2 months.
Patient was apparently alright 2 months back when he started complaining of dull aching abdominal pain, insidious in onset, gradually progressive in intensity, intermittent in nature not associated with vomiting. Patient also complained of few episodes of per rectal bleed. No other aggravating or relieving factors were present.

Patient had no other significant family, past or personal history.
There was no history of any other coexisting comorbidities.
Per abdomen was soft, non-tender, no guarding or rigidity was present. No obvious lump was palpable.
Digital rectal examination was within normal limits with no growth felt and no evidence of active per rectal bleed.

Radiological Findings
CECT (A+P) was suggestive of circumferential asymmetric growth in mid descending colon for a length of 3.8cm and thickness of 1.9cm with peri-colon fat stranding present. There was presence of another fat attenuating intraluminal lesion in proximal ileum of approximate size 1.2x1cm causing ileo-ileal intussusception. No evidence of metastasis present.
Colonoscopy was suggestive of ulcero-proliferative growth in the descending colon beyond splenic flexure, lumen-narrowing and multiple biopsies were taken and sent for histopathological examination. HPE was suggestive of poorly differentiated adenocarcinoma.

Management
Patient was evaluated pre-operatively in terms of fitness for surgery
S. CEA was borderline raised with a value of 5.8ng/ml. Patient was planned for a laparoscopic SOS open left hemicolectomy procedure. Patient initially underwent a diagnostic laparoscopy to look for metastases and tumour resectability and a medial to lateral approach was taken with initial ligation and clipping of Inferior Mesenteric Artery and Vein. Mass was identified just near splenic flexure for an approximate length of 2.5-3cm. Since omentum was firmly adhered to Gerota's fascia underneath laparoscopic dissection was not achievable and was converted to an open exploratory laparotomy.
Left Hemicolectomy was done with proximal 10cm and distal 5cm margin and end to end colo-colic stapler anastomosis was done between transverse and sigmoid colon.
On bowel walk, evidence of telescoping of bowel was seen at 50cm from duodeno-jejunal flexure suggestive of jejuno-jejunal intussusception. Bowel was opened at that site with the evidence of two intraluminal fatty globular structures of approximate size 4cmx3cm which probably served as the leading point for the intussusception. 10cm bowel was resected with jejuno-jejunal stapler anastomosis done.
Abdomen was then closed in layers after placing abdominal drain no.32 in left lumbar region near the site of anastomosis.
Patient was vitally stable post-operatively and was allowed orally on postoperative day 7 with drain removed on post op day 9. Patient was discharged on post op day 14 after suture removal.
Post op HPE was suggestive of: Poorly differentiated adenocarcinoma in resected descending colon specimen with negative proximal and distal margins. Jejunal intraluminal lesions were suggestive of 2 well-circumscribed, yellowish, soft, intraluminal polypoidal masses measuring 3x2cm and another measuring 4x3cm arising from the submucosa. Cut surface is homogeneously yellow, greasy, and lobulated, suggestive of adipose tissue. Sections show a well-demarcated submucosal lesion composed of mature adipocytes. The adipocytes are uniform, with clear cytoplasm and eccentric nuclei, without atypia or lipoblasts. No evidence of malignancy, cellular atypia, or necrosis. No mitotic activity seen.

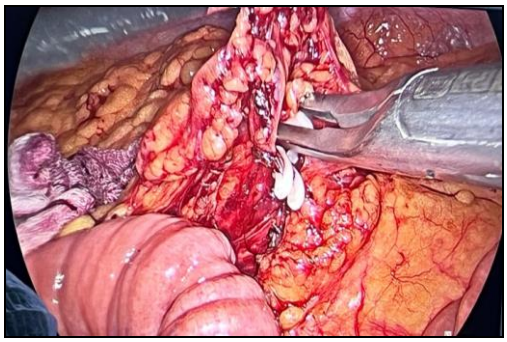

Fig 1: Laparoscopic dissection from medial to lateral

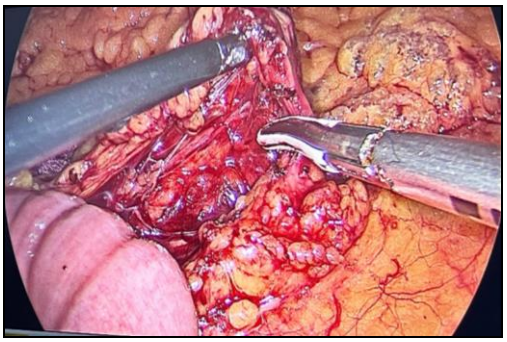

Fig 2: Ligation and clipping of IMA and IMV

Fig 3: Jejuno-Jejunal Intussusception secondary to intraluminal lipoma

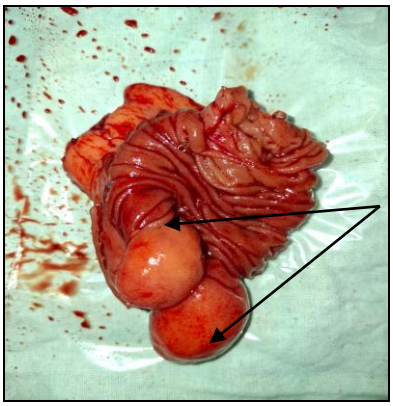

Fig 4: Gross specimen photo of resected jejunum with evidence of two intraluminal lipomas

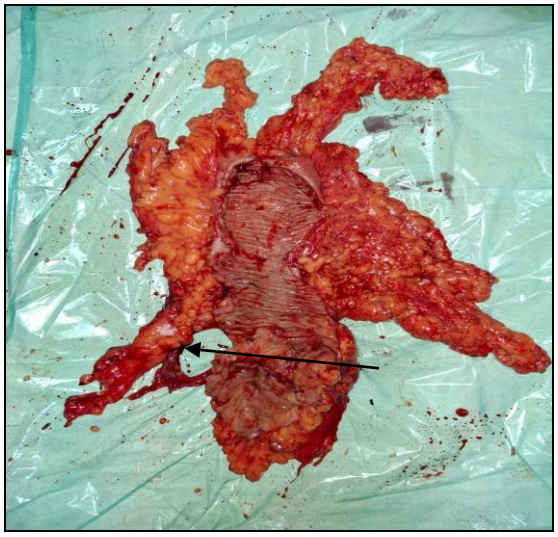

Fig 5: Gross specimen photo of resected descending colon with proximal 10cm and distal 5cm margin with evidence of intraluminal ulcero-proliferative growth

Discussion

Adult intussusception is a rare clinical condition, comprising only 1-5% of all intestinal obstructions and around 5% of all intussusception cases, with a markedly different aetiology from its paediatric counterpart. In adults, over 90% of cases have a pathological lead point, with benign tumours such as lipomas being responsible for a significant minority of small bowel cases [1]. Jejunal lipomas, though uncommon, are recognized causes of intussusception, particularly when intraluminal and pedunculated [2].

Colorectal carcinoma, on the other hand, is one of the most prevalent malignancies worldwide. Left-sided colon cancers including those in the descending colon typically present with altered bowel habits, per rectal bleeding, and anaemia. In our patient, the mid-descending colon carcinoma presented with non-specific abdominal pain and intermittent per rectal bleeding, which is typical of more distal lesions [3].

The incidental finding of jejuno-jejunal intussusception in this case identified on imaging and confirmed intraoperatively adds a unique dimension. Intussusception in adults is rarely diagnosed preoperatively due to non-specific symptoms and often mimics other gastrointestinal disorders. In many cases, including ours, intussusception may be asymptomatic and identified only on imaging or during laparotomy [4]. Contrast-enhanced CT is the most sensitive modality, showing a characteristic "target" or "sausage-shaped" soft-tissue mass, which helped raise suspicion in this patient [5].

The coexistence of descending colon adenocarcinoma with jejunal lipoma-induced intussusception is exceedingly rare, and only isolated cases have been reported in literature [6]. The synchronous presence of two distinct pathologies emphasizes the need for careful preoperative imaging and comprehensive intraoperative bowel assessment. Timely surgical intervention with appropriate resection and anastomosis, as performed in our case, ensures favourable outcomes and prevents complications such as obstruction, bleeding, or perforation.

Histopathological confirmation remains essential. In our patient, the colon lesion was a poorly differentiated adenocarcinoma, and the jejunal lesions were benign submucosal lipomas. This highlights that not all incidental lesions represent malignant disease, but their identification can significantly influence surgical planning.

Conclusion

This case illustrates a rare synchronous occurrence of mid-descending colon carcinoma and jejunal lipoma-induced intussusception, discovered incidentally on imaging and confirmed intraoperatively. While both conditions are known independently, their coexistence is unusual and diagnostically challenging. The case underlines the value of thorough preoperative evaluation, careful intraoperative bowel examination, and multidisciplinary surgical management. Such vigilance ensures detection and appropriate treatment of multiple pathologies that may otherwise go unnoticed, ultimately improving patient outcomes.

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