

COMMENT ON: GIANT OMENTAL LIPOMA

We read with interest the case report by Tan and Chan.⁽¹⁾ The purpose of this communication is to highlight a few points relevant to computed tomography (CT) and magnetic resonance (MR) imaging of intra-abdominal lipoma, which is a benign fatty tumour, as well as its differentiation from well-differentiated liposarcoma, especially the 'lipoma-like' histological subtype.⁽²⁻⁴⁾

Both lipomas and well-differentiated liposarcomas appear as fatty masses and can closely mimic each other on CT and MR imaging.^(4,5) However, it is important to make a distinction between the two entities. Well-differentiated liposarcomas are generally managed by wide local excision, as they can have local recurrence and also require follow up due to their propensity for delayed dedifferentiation, which may occur after 5–10 years of surgical removal.^(5,6) Well-differentiated liposarcomas occur between the 4th and 7th decades, without any gender predilection.⁽³⁾ Although the usual sites of occurrence of liposarcomas are in the extremities and retroperitoneum, mesenteric and omental liposarcomas are also known to occur in these locations.^(2,5) Benign lipomas are typically seen as encapsulated homogeneous low-attenuation mass lesions on CT, and show homogeneous high signal intensity on T1- and T2-weighted MR imaging.⁽⁵⁾ However, the identification of any of these features on CT and MR imaging, such as thick (> 2 mm) irregular or nodular septation, nodular areas of non-fatty foci and septal contrast enhancement, should raise suspicion of a well-differentiated liposarcoma.^(3,4,6)

We would like to share our experience of a similar case of a large mesenteric lipoma in a 41-year-old man who presented with abdominal pain of three days' duration. On contrast-enhanced CT, acute diverticulitis of the ascending colon was detected. In addition, there was a large (10.6 cm × 6.7 cm × 8.5 cm), well-defined, encapsulated, homogeneous fat attenuation lesion in the left upper abdomen. No enhancing solid component, thick septation or calcification was detected (Fig. 1). After the management of acute diverticulitis, an exploratory laparotomy was performed, with resection of the mass lesion, which was noted to arise from the proximal small bowel mesentery. Histopathological examination confirmed the finding of a benign lipoma. No evidence of malignancy was detected.

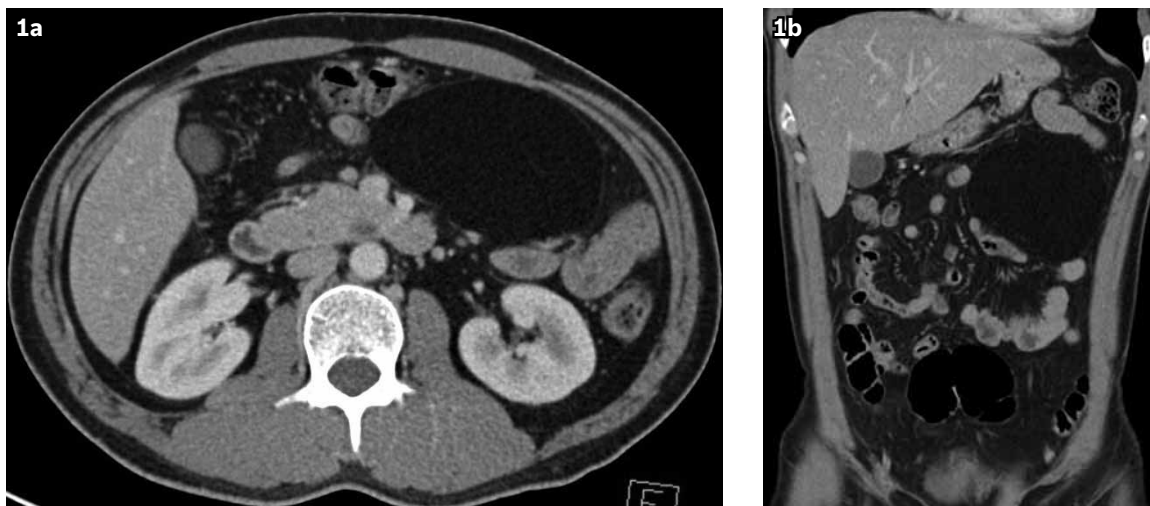


Fig. 1 (a) Axial and (b) coronal CT images show a well-defined, encapsulated fatty lesion in the small bowel mesentery, which was pathologically proven as a benign lipoma.

In summary, we emphasise the role of preoperative imaging in a suspected case of intra-abdominal lipoma in order to detect features that could raise suspicion of the rare but clinically important entity of a well-differentiated liposarcoma. This also has potential implication as a guide to adequate surgical planning.

Yours sincerely,

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Editor's note: The authors, Tan and Chan, have declined to respond to the above letter.