Letters to the Editor

Submucosal lipoma of the colon with intussusception

Sir,

We read with interest the paper by Stephen P. Courtney, and colleagues on intussusception in the adult.¹ This has prompted us to report our case of a submucosal lipoma of the colon presenting with intussusception.

A 62 year old man presented with a 5 day history of passing fresh blood per rectum associated with colicky abdominal pain. He complained of tenesmus but each time he tried to defaecate, he only passed blood. On examination he was found to be in pain without any localized tenderness or guarding in the abdomen. Rectal examination revealed a smooth 5 cm mass with a soft consistency. On sigmoidoscopy the mass had a smooth mucosal lining and looked ischaemic with superficial ulcerations. A clinical diagnosis of a submucosal lipoma was made and a barium enema was performed. This was reported as showing an intussuscepting polypoid lesion in the sigmoid colon which failed to reduce. At laparotomy the barium enema findings were confirmed and a limited sigmoid colectomy was performed. The patient made an uneventful postoperative recovery and histology confirmed the diagnosis.

Gastrointestinal submucosal lipomas are rare. The highest incidence is found in the colon.² There is a female predominance.³ The majority are asymptomatic and when symptomatic they present most commonly in the sixth decade. They have been known to cause intra-abdominal pain, constipation, diarrhoea, obstruction, bleeding and intussusception.^{3–5} Symptoms seem to be related to size and are commoner in lipomas greater than 2 cm in diameter.³ Diagnosis before laparotomy is uncommon.⁶ Two thirds of all lipomas are found in the right colon whereas the majority of carcinomas arise in the left.³

Barium enema and colonoscopy are helpful in diagnosis. Recently, computerized tomography and endoscopy have been recognized as valuable diagnostic tools in differentiating colonic lipomas from more common adenomatous polyps and carcinomas.^{7,8} Endoscopy will miss subserosal lipomas which account for 10% of all colonic lipomas.⁹ Lipomas can be removed by simple colotomy or by myotomy and enucleation. Attempts to diagnose this condition preoperatively saves the patient a more radical colectomy for a suspected carcinoma.

M.N. Siddiqui
J.R. Garnham¹

Department of Surgery,
The Aga Khan University Hospital,
Karachi, Pakistan
and ¹Mount Vernon Hospital,
Northwood,
Middlesex, UK.

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Electrocardiographic Q-Tc prolongation associated with infusion of intravenous pamidronate disodium

Sir,

Pamidronate disodium (APD: 3-amino-1-hydroxypropylidene-1-diphosphonate) is used increasingly in the treatment of hypercalcaemia of malignancy, Paget's disease, and osteoporosis. It is a potent inhibitor of bone resorption and may act by inhibiting osteoclastic function.¹ We report prolongation of the Q-Tc interval in a patient treated with pamidronate.

A 71 year old female with a history of malaise, anorexia and vaginal bleeding was found to have metastatic squamous cell carcinoma of the cervix. She was taking no medications. Biochemical investigations demonstrated normal sodium, potassium, phosphate and urea concentrations. The calcium was 3.14 mmol/l (normal 2.2–2.6 mmol/l) with an albumin of 27 g/l and alkaline phosphatase of 429 U/l (normal 90–280 U/l). The electrocardiogram (ECG) on day 1 demonstrated normal sinus rhythm with normal axis, PR interval, QRS width and Q-Tc interval (0.43 seconds as calculated by Bazett's formula).

The hypercalcaemia was treated initially with vigorous (5 litres/hour) intravenous rehydration with isotonic saline. On day 3, 30 mg of pamidronate was given intravenously in 250 ml isotonic saline over 4 hours. The serum calcium, however, increased over the next few days to 3.69 mmol/l (albumin 27 g/l) on day 7 and a further 30 mg of pamidronate was administered intravenously.

The patient's clinical condition improved but the serum calcium decreased to 2.0 mmol/l (albumin 26 g/l) on day 13 and then to 1.76 mmol/l (albumin 25 g/l) on day 15 and