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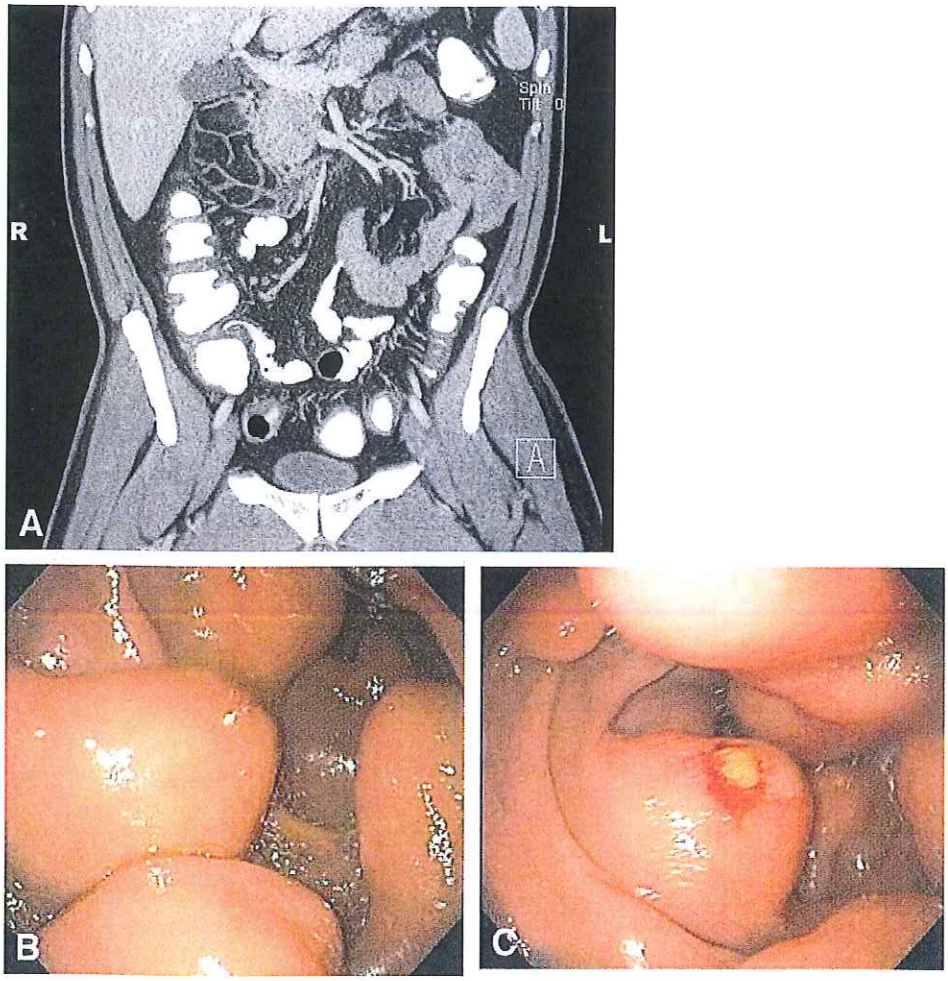
AQ: 1

Duodenal lipomatosis



A 54-year-old man with a history of tonsillar cancer had a follow-up CT scan, which showed incidental duodenal lipomatosis (**A**). Two years later, upper endoscopy was performed to evaluate acid reflux. A small hiatus hernia was observed. Starting at the distal end of the bulb and leading to the third part of the duodenum were 10 submucosal lesions 0.5 to 2.0 cm in diameter (**B**). Probing with the forceps resulted in a shallow pillow sign, and biopsies of three nodules resulted in exposure of underlying fat (**C**). Pathologic examination revealed typical findings of a submucosal lipoma.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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http://dx.doi.org/10.1016/j.gie.2013.01.037

Commentary

Although first described more than a century ago, by Hellstrom in 1906, small intestinal lipomatosis remains a rare condition. Isolated lipomas are much more frequently encountered and, in the small intestine, are most common in the ileum. Lipomatosis affects both genders equally and typically occurs after the fourth decade of life. The lipomas in this condition are usually located in the submucosa but may extend through the bowel wall and into the serosal or mesenteric fat. Lipomas usually are silent, but they may ulcerate and bleed, or they may cause colicky abdominal pain because of intussusception. Jejunal lipomatosis has been reported in association with jejunal diverticulosis, ostensibly due to involvement and attenuation of the muscularis propria. CT scanning or CT enterography is the preferred diagnostic test for intestinal lipomatosis, although capsule endoscopy also can play a valuable role in demonstrating the lipomas. If within reach of the endoscope, a biopsy forceps may be used in several ways to prove the diagnosis. Before biopsy of the putative lipoma, however, the diagnosis might be suspected because of blood vessels that may be seen coursing over the lesion's surface or an orange-red surface that changes to a more yellow color toward the base of the lesion. As the lesion is probed with a closed biopsy forceps, it indents and then springs back to its previous shape when the forceps is withdrawn: the so-called "pillow sign." Immediately before the biopsy specimen is taken, the mucosa may be grasped with the forceps and pulled up: the so-called "tenting sign." Upon biopsy, one may evoke the "naked fat sign," a finding pathognomonic for lipoma during which fat spills out of the lesion after the biopsy. St Jerome said a fat stomach never breeds fine thoughts. Times have changed, and besides the insensitivity of the comment, I am sure he was referring to the abdomen, not the stomach, and that he had never heard of lipid islands in the stomach or gastrointestinal lipomatosis. AQ: 2

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