CLINICAL VIGNETTE

Lymphangioma of the Colon

Daniel Eshtiaghpour, MD and Tina Storage, MD

Case Presentation

A 55-year-old male presented to the gastroenterologist with one month of right lower quadrant pain. He reports that the pain occurs in the morning and worsens if he bends over and twists. The abdominal pain improves with defecation, and he reports one bowel movement a day. He denies any blood in his stool, diarrhea, or constipation. His past medical history includes remote history of kidney stones. He denied smoking, alcohol consumption, or recreational drugs. There is no family history for any gastrointestinal malignancies.

At the initial visit, vital signs were within normal limits and Cardiopulmonary examination was also normal. Abdominal exam included no distention or visible masses and normal bowel sounds. The abdomen was soft and nontender without organomegaly.

Labs included hemoglobin level of 14.6 g/DL, white blood cell count of 6.5 x10E3/uL and platelets of 314 K/uL. Comprehensive metabolic panel was normal.

Abdominal computed tomography was normal and colonoscopy scheduled under monitored anesthesia care. Colonoscopy noted a large 3 cm hepatic flexure pedunculated cystic lesion (see Figures 1 and 2). Given the large size of the lesion, tattoo was placed, and the patient was scheduled for repeat colonoscopy. Repeat colonoscopy confirmed the 3 cm sessile polypoid lesion at the hepatic flexure with a potentially cystic component. A 1 cm focus of potential serrated change was seen overlying the lesion, and it was decided to proceed with resection. The lesion was successfully removed with endoscopic mucosal resection. A target sign was seen within the defect, so it was tightly closed with size 17 mm hemoclips and no bleeding was noted with submucosal ink tattoo for future localization. Histopathology showed a 0.1 cm cystic wall surface which appears smooth to minimally roughed (see Figures 3, 4 and 5). The cystic spaces are devoid of contents consistent with a cystic lymphangioma of the colon. Cauterized margins were free of lymphatic tissue involvement.

Discussion

Lymphangioma of the colon is a submucosal tumor covered with normal mucosa. Lymphangiomas are uncommon benign tumors arising from lymphatics involving various parts of the body.[1] Lymphangiomas are mostly seen in the head and neck. Histologically, they may have single or multiple locules containing liquid contents and are lined with a single layer of endothelium. These lesions can be found anywhere in the body. The abdomen is an uncommon location. Within the abdomen most arise in the mesentery, omentum, mesocolon and retroperitoneum. They rarely arise from the wall of the intestine. The reported age distribution is 1-83 years, with 60 years most frequent.[2] The size of the mass is variable, up to 23 cm, and unrelated to age or location.

Most colonic lymphangiomas are small asymptomatic tumors. When present, symptoms are usually nonspecific. There may be acute abdominal pain with or without bloody stools, diarrhea and constipation depending on size and location. There have been also instances of infection, intussusception, anemia and protein losing enteropathy. There are no known cases of these tumors transforming into malignancy.[3]

Biopsy with cold forceps may not yield results given the submucosal location of the lesion. Diagnosis can be made by endoscopic ultrasound, where the lesions appear as anechoic, septate, and submucosal. Fine needle aspiration may show a paucity of cells.[4] Given that larger lesions have a propensity to lead to acute complications, endoscopic or surgical management should be considered. Thus far, endoscopic removal has been for lesions up to a maximum of 3.5 cm. Endoscopic therapy is associated with less morbidity and lower healthcare costs.

Figures

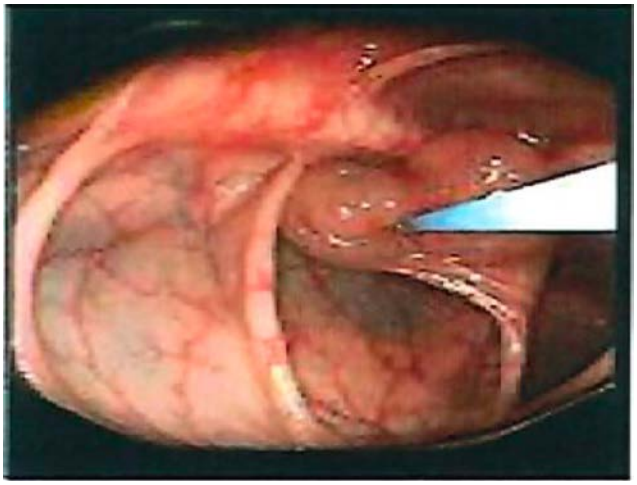

Figure 1.

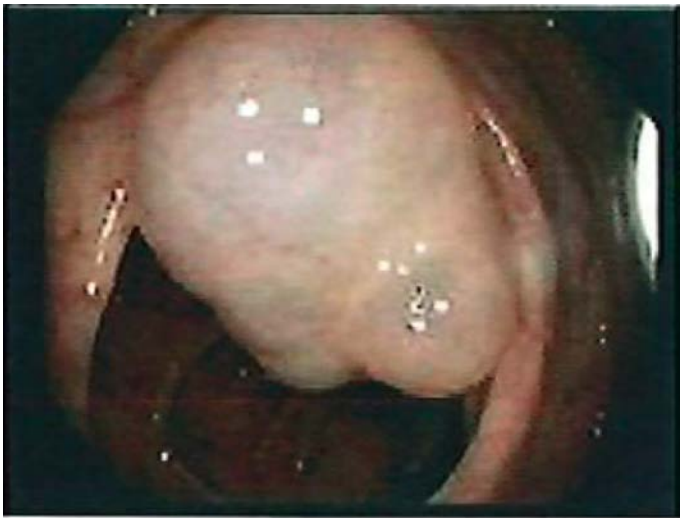

Figure 2.

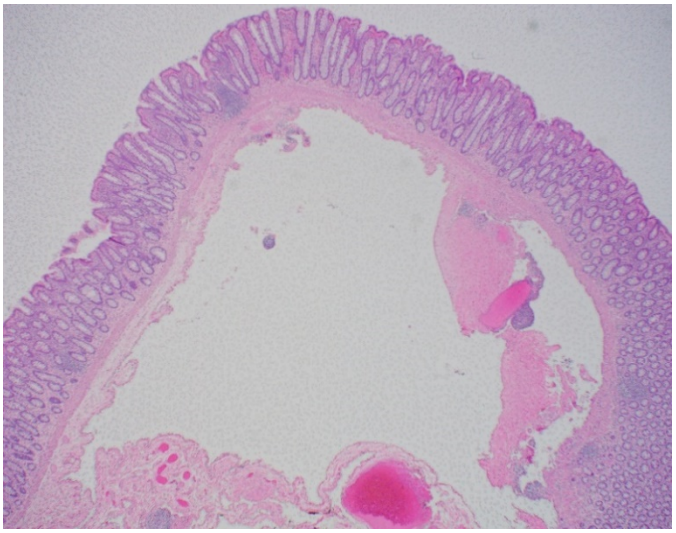

Figure 3.

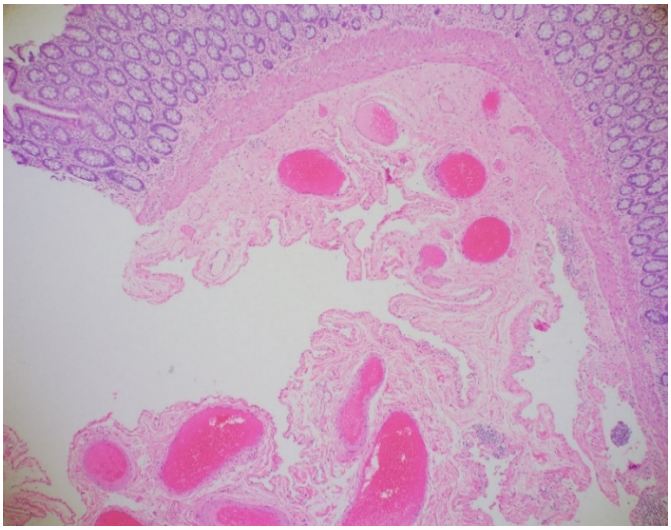

Figure 4.

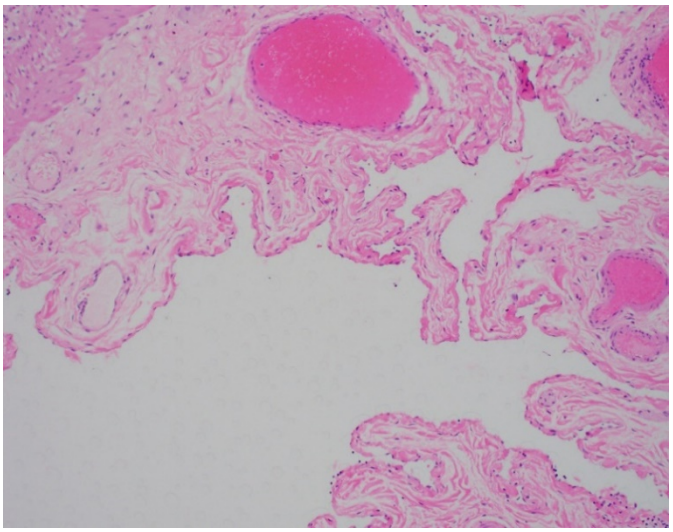

Figure 5.

REFERENCES

1. **Kulkarni J, Bhat N, Pai SA**. Cystic lymphangioma of the colon. *Indian J Gastroenterol*. 2009 Dec;28(6):197. doi: 10.1007/s12664-009-0077-1. PMID: 20177865.
2. **Matsuda T, Matsutani T, Tsuchiya Y, Okihama Y, Egami K, Yoshioka M, Maeda S, Onda M**. A clinical evaluation of lymphangioma of the large intestine: a case presentation of lymphangioma of the descending colon and a review of 279 Japanese cases. *J Nippon Med Sch*. 2001 Jun;68(3):262-5. doi: 10.1272/jnms.68.262. PMID: 11404774.
3. **Lu G, Li H, Li Y**. Lymphangiomatosis of the sigmoid colon - a rare cause of lower gastrointestinal bleeding: A case report and review of the literature. *Oncol Lett*. 2017 Jan;13(1):339-341. doi: 10.3892/ol.2016.5399. Epub 2016 Nov 21. PMID: 28123564; PMCID: PMC5244848.
4. **Kochman ML, Wiersema MJ, Hawes RH, Canal D, Wiersema L**. Preoperative diagnosis of cystic lymphangioma of the colon by endoscopic ultrasound. *Gastrointest Endosc*. 1997 Feb;45(2):204-6. doi: 10.1016/s0016-5107(97)70253-0. PMID: 9041015.