Title:
Ileal Lipohyperplasia Masquerading as Stricturing Crohn’s Disease

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Funding
None

Conflict of Interest:
The authors disclose no conflicts.

Ethical Statement
The corresponding author, on behalf of all authors, jointly and severally, certifies that their institution has approved the protocol for any investigation involving humans or animals and that all experimentation was conducted in conformity with ethical and humane principles of research.

Keywords: small bowel stricture, small bowel obstruction, ileal lipohyperplasia
47-year-old male with stricturing Crohn’s disease (CD) presented with intermittent right-lower-quadrant-abdominal pain (RLQAP), nausea/vomiting, and constipation.

History revealed small bowel resections (age 20/32 years) followed by 9-years symptomatic remission with sulfasalazine, which was discontinued 7 years ago (medical insurance lapse). For 6-years, he had mild, intermittent, self-resolving RLQAP with nausea/vomiting that became more frequent two months ago, necessitating two hospitalizations (unremarkable esophagastroduodenoscopy, colonoscopy, barium enema).

On presentation, he had mild RLQAP and tenderness without rebound/distention. Magnetic resonance enterography showed 4-cm dilated distal ileum (Figure-A, asterisk), with 3x0.6 cm stricture proximal to ileocecal valve (Figure-A, arrow). Ileo-cecectomy revealed prominent adipose tissue in the submucosa between the mucosa and muscularis propria (Figure-B, right brace) and dilated lymphatic vessels in the terminal ileum (Figure-C, arrows) without evidence of CD.

This is the first case of lipohyperplasia causing small bowel stricture/obstruction in CD. Although management is still resection, lipohyperplasia should be considered in the differential diagnosis of small bowel stricture even in patients with known stricturing CD.