A rare case of giant pseudopolyp and colitis cystica profunda coexistence in an ulcerative colitis patient

Dear Editor,

Here we report an unusual finding in a 39-year-old man affected by ulcerative colitis (UC) with a 10-year history of flares treated with systemic steroids, who achieved clinical remission assuming 50 mg/daily azathioprine during the last year.

A follow-up colonoscopy showed an ulcerative pancolitis in endoscopic remission, with diffused scarring areas and numerous pseudopolyps in the whole colon, maximum 10 mm in size. Particularly, a sessile polypoid mass covered by regular mucosa, 4 cm in size, was detected in the descending colon (Fig. 1A). After biopsies of the mass, a leakage of slightly yellow mucus was noted with subsequent formation of residual cystic-like cavities. Histological examination of the mass and colon revealed a quiescent disease without dysplasia or malignancy. Abdominal CT confirmed the 4 cm polypoid mass in the descending colon without obstructive, infiltrative or metastatic aspects (Fig. 1B).

Because of the dimension of the polyp, with the risk of bowel obstruction and occult malignancy, the patient underwent segmental colonic resection (Fig. 1C). Histological examination of the surgical specimen revealed a giant pseudopolyp with basal aspects of colitis cystica profunda (CCP) with mucin-filled cysts permeating muscularis propria (Fig. 1D). Neither cellular atypia nor immunohistochemical p53 reactivity was present (Fig. 1E). The surrounding colon showed a chronic colitis without aspects of CCP (Fig. 1F).

Discussion

Giant pseudopolyps are rare complications of UC resulting from a regenerative and healing process that leaves inflamed colonic mucosa in a polypoid configuration larger than 1.5 cm. They consist of exuberant granulation tissue and fibrosis and are known to occur in both UC and Crohn’s disease. Usually asymptomatic, they may rarely function as a lead point in causing intussusceptions or bowel obstructions (1). Giant pseudopolyps generally have an indolent nature, nevertheless occult malignancy within a giant pseudopolyp has been described in literature (2). A careful endoscopic vigilance and a radiographic follow-up are thus necessary in these patients. Due to the risk of bowel obstruction connected to their large size and the slightly risk of malignancy, surgical resection of the affected colon segment is often the preferred treatment (1).

CCP is a rare benign condition of unknown etiology, in which the colonic submucosa and occasionally the muscularis propria contain mucous cysts that may occur focally or diffusely in large or small intestine (3). When CCP is suspected, mucinous adenocarcinoma should be excluded (3). Rare cases of CCP occurring in the background of UC have been reported. Option treatments include conservative pharmacological measures, such as corticosteroid enemas, or surgery (4).

The coexistence of a giant pseudopolyp and CCP has been only described in a previous case in Crohn’s colitis, while such an association has never been reported in UC patients (5). It may be...
speculated that giant inflammatory pseudopolyp and CCP could be a result of overacting epithelial reactions induced by the long-standing inflammatory process that characterizes inflammatory bowel diseases. Our case emphasizes the variety of histological aspects that may occur during the course of UC. Clinicians should consider the possibility of an association between CCP and giant pseudopolyps also in UC patients.

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References


Fig. 1. A. Endoscopic view. B. CT scan. C. Surgical specimen. D. Giant pseudopolyp. E. Basal aspects of colitis cystica profunda with mucin-filled cysts permeating muscularis layer. F. Surrounding colonic mucosa with chronic colitis without aspects of colitis cystica profunda.