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doi:10.3748/wjg.15.877

*World J Gastroenterol* 2009 February 21; 15(7): 877-878
***World Journal of Gastroenterology*** ISSN 1007-9327


*CASE REPORT*

# An obstructing mass in a young ulcerative colitis patient

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Received: April 25, 2008 Revised: May 13, 2008
Accepted: May 20, 2008
Published online: February 21, 2009

## Abstract

We present a case of a 19-year-old female who developed subacute obstruction due to giant inflammatory polyps, having undergone treatment for left-sided ulcerative colitis. This is followed by a review of the literature.



**Key words:** Pseudopolyp; Ulcerative colitis; Inflammatory polyps; Giant intestinal polyposis

**Peer reviewers:** Jay Pravda, MD, Inflammatory Disease Research Center, Gainesville, Florida, 32614-2181, United States; Dr. Bret Lashner, Cleveland Clinic, 9500 Euclid Ave, Cleveland OH 44195, United States

Zeki S, Catnach S, King A, Hallan R. An obstructing mass in a young ulcerative colitis patient. *World J Gastroenterol* 2009; 15(7): 877-878 Available from: URL: http://www.wjgnet.com/1007-9327/15/877.asp DOI: http://dx.doi.org/10.3748/wjg.15.877

## INTRODUCTION

Giant inflammatory polyps occur rarely in ulcerative colitis patients. The presentation is often insidious and the endoscopic appearance can be alarming. The following case illustrates these points.

## CASE REPORT

A 19-year-old female student presented to Hemel Hempsted General Hospital in May 2006 following a 20-d history of bloody diarrhea. The patient was on no regular medications at the time of admission. She had no significant past medical history apart from iron deficiency anemia [hemoglobin 7.4 g/dL, mean corpuscular volume (MCV) 67.3] with raised inflammatory markers (C-reactive protein; CRP, 89 mg/L). Flexible sigmoidoscopy demonstrated left-sided colitis and subsequent biopsies confirmed it to be ulcerative colitis. She received a short course of oral prednisolone (40 mg) and balsalazide (2.25 mg *tds*) with rapid improvement. At the time of her follow-up appointment in July 2006, she was asymptomatic.

At a subsequent clinical appointment in September 2006, the patient complained of increasing nausea, lethargy and borborygmi. Blood taken at the time revealed a microcytic anemia (hemoglobin 9.8 g/dL, MCV 78) despite being on ferrous sulfate and an albumin of 19 g/L. Her CRP was < 3 mg/L. She was readmitted to our hospital in November 2006 having developed 10 episodes of watery diarrhea a day. She was treated with steroids for exacerbation of colitis, started on azathioprine and discharged from our hospital. Over the subsequent months, the patient continued to complain of worsening lower abdominal pain, vomiting and lethargy. She was readmitted for investigation and her admission blood analysis revealed CRP < 3 mg/L. Her abdominal X-ray was unremarkable. She underwent a flexible sigmoidoscopy to assess the extent of inflammation. There was no evidence of active ulcerative colitis, but the discovery of a mass at the splenic flexure prompted further imaging with computed tomography (Figure 1). Because of the obstructive nature of the mass and the fact that the mass extended along the transverse colon, the patient underwent an extended right hemicolectomy with primary anastomosis (Figure 2). The histology of the mass revealed it to be an inflammatory pseudo-polyp with no evidence of dysplasia. She subsequently made a good postoperative recovery with a normalization of all blood results.

## DISCUSSION

Giant inflammatory polyps (GIPs), also known as filiform polyposis or pseudo-polyps, are defined as being more than 1.5 cm in diameter. First described in 1965[1,2], they can occur in both ulcerative colitis and Crohn's disease,

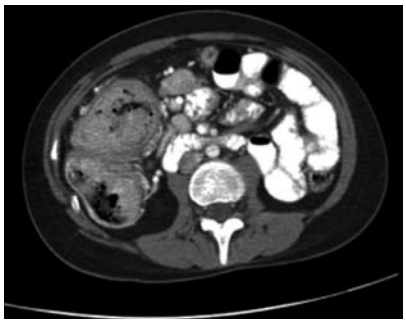

**Figure 1 Abdominal computed tomography showing a mass at the splenic flexure.**

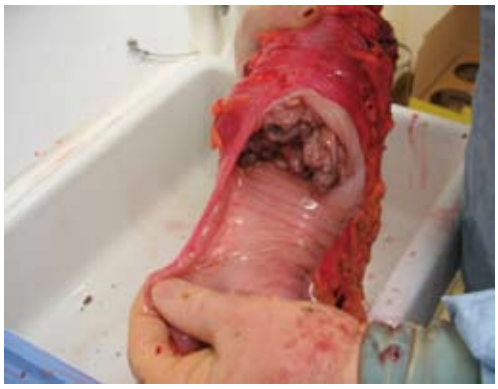

**Figure 2 Resected specimen revealing an inflammatory pseudo-polyp with no evidence of dysplasia.**

although the former is more common. They occur most commonly in females with pancolitis at the age of 20-40 years, diagnosed 1-5 years prior to presentation with GIPs. There is a predilection for the transverse colon, although the condition has been described at all colonic sites. GIPs can present in a number of different ways, including crampy abdominal pain, anemia, obstruction, hypoproteinemia and palpable abdominal mass[3-8].

Its presentation and endoscopic findings may mimic those of a colonic tumor. There are no pathognomonic signs to confidently differentiate colonic pseudo-polyp clinically, radiologically or endoscopically from villous adenoma, dysplasia-associated lesion or mass or carcinoma[9]. The pathogenesis is deemed to be abnormal healing in the form of enthusiastic post-inflammatory regeneration[9-11]. GIPs have been found in both quiescent and active diseases[12] which may represent detection at different stages in their development. Balazs has found further evidence for this[13] from the histopathological analysis of GIPs which shows changes similar to those described in delayed type hypersensitivity[14]. Treatment is currently surgical in all previously described case reports, as most of the patients present with obstruction, and because of the size of the polyp.

We believe that GIPs should be suspected more often in young patients with colitis presenting with obstruction. Hypoalbuminemia is an interesting aspect that has been previously reported and attributed to an etiology similar to that of Menetrier's disease. Although non-specific in the appropriate clinical context, its presence should add further suspicion for the presence of GIPs[15,16].

## REFERENCES


1 **Goldgraber MB**. Pseudopolyps in ulcerative colitis. *Dis Colon Rectum* 1965; **8**: 355-363
2 **Bernstein JR**, Ghahremani GG, Paige ML, Rosenberg JL. Localized giant pseudopolyposis of the colon in ulcerative and granulomatous colitis. *Gastrointest Radiol* 1978; **3**: 431-435
3 **Yada S**, Matsumoto T, Kudo T, Hirahashi M, Yao T, Mibu R, Iida M. Colonic obstruction due to giant inflammatory polyposis in a patient with ulcerative colitis. *J Gastroenterol* 2005; **40**: 536-539
4 **de Dombal FT**, Watts JM, Watkinson G, Goligher JC. Local complications of ulcerative colitis. Stricture, pseudopolyps and cancer of the colon and rectum. *Am J Proctol* 1967; **18**: 198-201
5 **Fitterer JD**, Cromwell LG, Sims JE. Colonic obstruction by giant pseudopolyposis. *Gastroenterology* 1977; **72**: 153-156
6 **Kirks DR**, Currarino G, Berk RN. Localized giant pseudopolyposis of the colon. *Am J Gastroenterol* 1978; **69**: 609-614
7 **Wills JS**, Han SS. Localized giant pseudopolyposis complicating granulomatous ilecolitis. *Radiology* 1977; **122**: 320
8 **Forde KA**, Gold RP, Holck S, Goldberg MD, Kaim PS. Giant pseudopolyposis in colitis with colonic intussusception. *Gastroenterology* 1978; **75**: 1142-1146
9 **Buchanan WM**, Fyfe AH. Giant pseudopolyposis in granulomatous colitis. *J Pathol* 1979; **127**: 51-54
10 **Ooi BS**, Tjandra JJ, Pedersen JS, Bhathal PS. Giant pseudopolyposis in inflammatory bowel disease. *Aust N Z J Surg* 2000; **70**: 389-393
11 **Katz S**, Rosenberg RF, Katzka I. Giant pseudopolyps in Crohn's colitis. A nonoperative approach. *Am J Gastroenterol* 1981; **76**: 267-271
12 **Ferguson CJ**, Balfour TW, Padfield CJ. Localized giant pseudopolyposis of the colon in ulcerative colitis. Report of a case. *Dis Colon Rectum* 1987; **30**: 802-804
13 **Balazs M**. Giant inflammatory polyps associated with idiopathic inflammatory bowel disease. An ultrastructural study of five cases. *Dis Colon Rectum* 1990; **33**: 773-777
14 **Dvorak AM**, Mihm MC Jr, Dvorak HF. Morphology of delayed-type hypersensitivity reactions in man. II. Ultrastructural alterations affecting the microvasculature and the tissue mast cells. *Lab Invest* 1976; **34**: 179-191
15 **Koinuma K**, Togashi K, Konishi F, Kirii Y, Horie H, Okada M, Nagai H. Localized giant inflammatory polyposis of the cecum associated with distal ulcerative colitis. *J Gastroenterol* 2003; **38**: 880-883
16 **Bryan RL**, Newman J, Alexander-Williams J. Giant inflammatory polyposis in ulcerative colitis presenting with protein losing enteropathy. *J Clin Pathol* 1990; **43**: 346-347


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