

Editor's quiz: GI snapshot

Recurrent colonic polyps

A 56-year-old man presented with a change in bowel habit to seven loose non-bloody stools a day. He had previously had a sigmoid resection for an endoscopic diagnosis of colonic malignancy in 2015. Histology of the resection specimen, however, had only shown inflammatory polyps, attributed to the accompanying diverticular disease.

His current colonoscopy showed two malignant looking lesions in the descending colon ([figure 1](#)) and the hepatic flexure ([figure 2](#)) with multiple additional sub-5 mm polyps in the ascending colon ([figure 3](#)). The intervening colonic mucosa was inflamed with appearances suggesting ulcerative colitis. A CT scan showed a 12

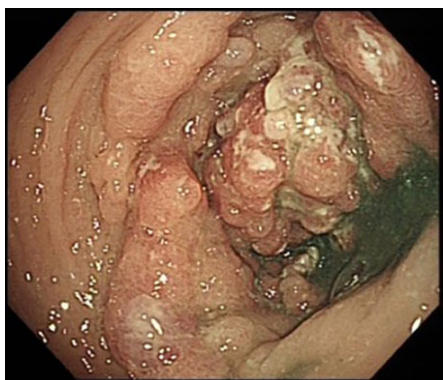


Figure 1 Endoscopic view of the descending colon lesion in white light imaging.

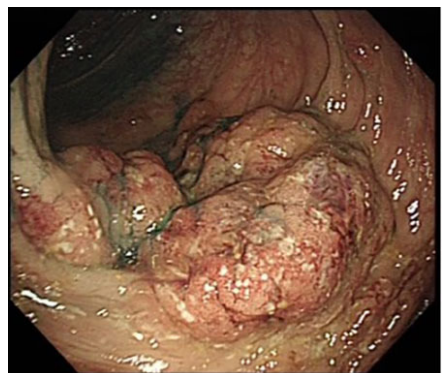


Figure 2 Endoscopic view of the hepatic flexure lesion in white light imaging.

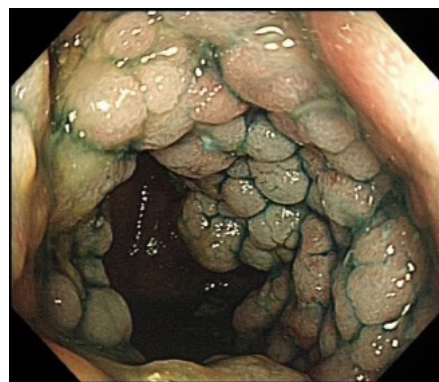


Figure 3 Endoscopic view of the ascending colon in white light imaging.

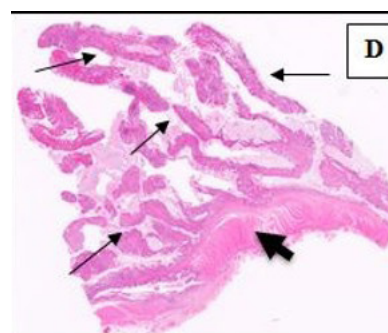


Figure 4 Wholemount section of colonic wall showing villiform mucosal fronds (black arrows) with intervening mucus and deep muscularis propria (arrowhead) (H&E).

cm segment of thickening at the hepatic flexure. Mucosal biopsies showed chronic active inflammation in the intervening mucosa in keeping with ulcerative colitis but there was no neoplasia in the lesional biopsies. In view of the persisting clinical and radiological concerns for malignancy, he underwent a subtotal colectomy following a multidisciplinary team discussion.

The resection specimen showed a large, friable, carpet-like polypoid mass within the ascending colon measuring 170×180 mm with other small polypoid lesions proximally. Within the left colon, there were two similar polypoid lesions, measuring 110×95 mm and 25×25 mm, and diverticular disease. Histology of these three lesions showed florid villiform projections of inflamed large bowel mucosa with no evidence of dysplasia or malignancy ([figure 4](#)).

QUESTION

What is the aetiology of the colonic lesions?

See page 960 for answer

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See page 888 for question

ANSWER

The endoscopic and histological features were consistent with giant inflammatory polyposis (GIP) associated with IBD. GIP is an uncommon benign lesion, usually associated with IBD.¹⁻³ Small inflammatory pseudopolyps are commonly seen in long-standing IBD and represent inflamed regenerating mucosa that projects above the level of the surrounding mucosa.⁴ Rarely, they can form large polyps, typically in the transverse or descending colon, forming a tumour-like mass, mimicking malignancy.³ These giant polyps occur in Crohn's disease and ulcerative colitis with similar frequency.⁴ They can also occur occasionally in diverticular disease of the sigmoid colon.⁵ Clinically, patients with GIP may have symptoms and signs similar to IBD including diarrhoea, rectal bleeding and anaemia, but the spectrum is varied, ranging from asymptomatic patients to patients presenting with colonic obstruction.^{3,6} Patients with GIP will often undergo colectomy due to clinical concerns of malignancy and frequent presentation with colonic obstruction. A high index of suspicion based on endoscopy and histology could result in avoidance of colectomy as medical therapy can be useful. For instance, complete regression of GIP has been reported after medical treatment of the underlying IBD with antitumour necrosis factor agents such as infliximab⁷ and adalimumab.⁸

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