A 38-year-old man was admitted for a colon polypectomy. A colonoscopic examination had been carried out in another hospital several days earlier due to hematochezia and a polyp had been found in the sigmoid colon. The 1.5-cm, pedunculated polyp (Fig. 1) had a slight bulge in the stalk, and there was a mucosal bridge at the attachment to the intestinal wall, mimicking a submucosal mass in the stalk.

The polyp was resected at the midportion of the stalk using an electrosurgical unit (ERBE VIO 300D, Elektromedizin GmbH, Tubingen, Germany) and snare (SD-9U-1, Olympus, Tokyo, Japan). Grossly, the resected specimen was composed of a head portion and stalk containing yellowish mucus. The remaining part of the stalk in the intestinal wall also contained the yellowish mucus (Fig. 2).

Histologic examination revealed that the polyp was a typical mixed adenomatous and hyperplastic type. There was abundant fibrous tissue and several dilated cystic glands in the submucosa, suggesting colitis cystica profunda (hematoxylin and eosin, magnification × 10). Typical tubular adenoma on the left and hyperplastic polyp on the right, with a distinctive transition between the two elements (hematoxylin and eosin, magnification × 40).

The dilated cystic gland deep within the stalk remnant was filled with mucin (Alcian blue stain, magnification × 12.5).

Fig. 1  Colonoscopy showing a 1.5-cm, pedunculated polyp in the sigmoid colon, with a bulging stalk and a mucosal bridge on the attachment of the colonic wall, implying the presence of a submucosal mass in the stalk.

Fig. 2  a, b After endoscopic polypectomy, part of the stalk remained attached to the intestinal wall and was seen to contain a large amount of yellowish mucus.

Fig. 3  a Histologically, the polyp was a mixed adenomatous and hyperplastic type. There was abundant fibrous tissue and several dilated cystic glands in the submucosa, suggesting colitis cystica profunda (hematoxylin and eosin, magnification × 10).

b Typical tubular adenoma on the left and hyperplastic polyp on the right, with a distinctive transition between the two elements (hematoxylin and eosin, magnification × 40).

c The dilated cystic gland deep within the stalk remnant was filled with mucin (Alcian blue stain, magnification × 12.5).
bular adenoma with low grade dysplasia, adjacent to which was a hyperplastic polyp (Fig. 3a, b). Also, there were multiple mucus-filled cysts under the muscularis mucosa. The cysts were covered with columnar epithelium and were surrounded by fibrous tissue. A large mucus pool in the epithelial lining was seen near the stalk remnant (Fig. 3c). We speculated that the pool of mucus within the stalk stump had resulted from submucosal invasion of the epithelial gland, as seen in colitis cystica profunda.

Colitis cystica profunda is a rare disorder in which benign, epithelial-lined, mucus-filled cysts, of unknown etiology, develop in the mucosa and submucosa of the colon and form polypoid lesions [1]. The disease is rarely accompanied by adenoma. A case report of a single polypoid colitis cystica profunda lesion accompanied by adenocarcinoma on the surface was recently published [2]. However, there has not been any report of a mucus pool within the stalk of a mixed hyperplastic and adenomatous colonic polyp, mimicking submucosal tumor, in colitis cystica profunda.

Competing interests: None

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References


Bibliography

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