

Endoscopic resection of a giant ileal inflammatory fibroid polyp by retrograde double-balloon enteroscopy

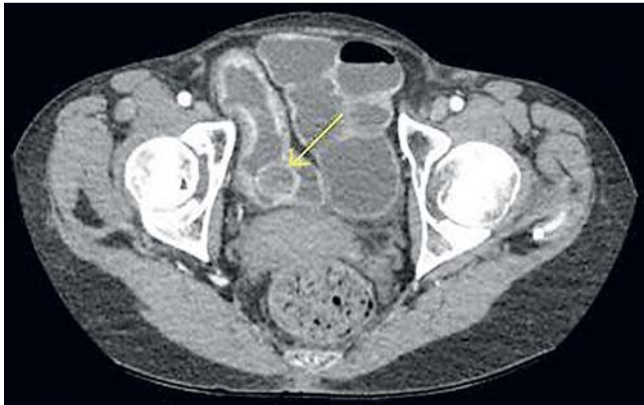


Fig. 1 Axial computed tomography enterography (CTE) image showing a polypoid lesion (arrow) projecting into the lumen of the distal ileum, the mucosa of which shows contrast hyperenhancement, consistent with inflammation.



Fig. 2 View during retrograde double-balloon enteroscopy (DBE) showing a large polypoid lesion in the distal ileum with an overlying cap of necroinflammatory exudate.



Fig. 3 Macroscopic appearance of the polyp, which was completely excised by en bloc endoscopic mucosal resection.

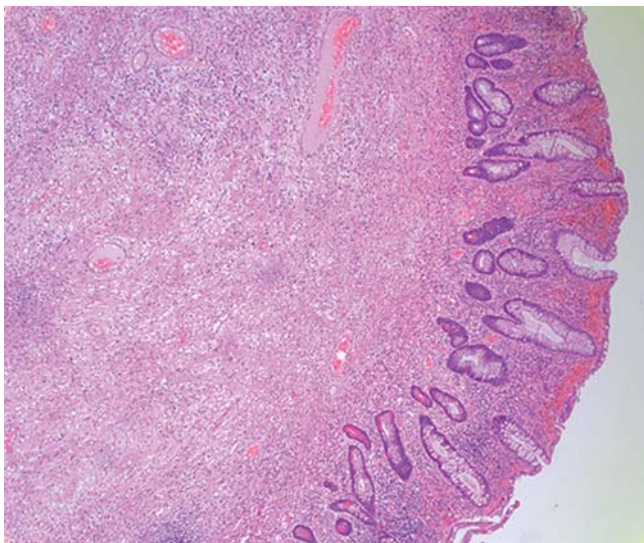


Fig. 4 Histopathological appearance of the hematoxylin and eosin (H&E)-stained excised submucosal lesion, which consisted of sparsely cellular proliferating spindle cells set within an edematous stroma containing small and large vessels and an inflammatory cell infiltrate that was rich in eosinophils (magnification $\times 10$).

A 70-year-old woman with a longstanding history of ileocolonic Crohn's disease was reviewed in our inflammatory bowel disease clinic. Although her Crohn's disease-related symptoms were well controlled on

azathioprine and 5-aminosalicylic acid therapy, computed tomography enterography (CTE) demonstrated active disease affecting the distal ileum and right colon with an ileal polyp that had increased in

size from 14 mm to 30 mm over a 2-year follow-up period (Fig. 1). Histopathology of biopsies taken from the distal ileal polyp were consistent with an inflammatory etiology but, because of its increasing size and the risk of intussusception, the lesion was deemed to merit endoscopic excision.

Retrograde double-balloon enteroscopy (DBE) identified the ulcerated polypoid lesion located within a segment of severely active Crohn's disease that was affecting the last 40 cm of the terminal ileum (Fig. 2). The head of the polyp was injected with a 1:10 000 epinephrine solution to reduce its size and bleeding risk [1]. The lesion was then removed by en bloc endoscopic mucosal resection (Fig. 3). Histopathological examination confirmed complete excision of a submucosal lesion composed of sparsely cellular proliferating spindle cells, set within an edematous stroma containing small and large vessels and inflammatory cell infiltrate rich in eosinophils (Fig. 4), consistent with an inflammatory fibroid polyp (IFP).

IFPs are rare benign submucosal lesions which, although they may arise anywhere within the gastrointestinal tract, affect the small bowel in only 18% of cases [2]. Intussusception, obstruction, and bleeding are recognized complications of small-bowel IFPs [3]. Simultaneous occurrence of active Crohn's disease with such lesions has rarely been described, and it has been proposed that disease activity may be the local stimulus for the formation of this apparently reactive lesion [4]. To the best of our knowledge, this is the largest small-bowel IFP (and only the third such case) to be resected by balloon-assisted enteroscopy [2, 5].

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Competing interests: None

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