A composite adenoma and carcinoid tumor in a single rectal polyp

A 64-year-old woman was referred to our endoscopic unit for investigation of abdominal pain. At colonoscopy we found a sessile polyp, 15 mm in diameter, in the middle part of the rectum (Figure **1**). Magnified chromoendoscopy using 0.2 % indigo carmine dye revealed a type IV pit pattern according to Kudo's classification, suggesting that the polyp was a good candidate for endoscopic resection. However, this polyp seemed to be taller than an ordinary sessile polyp, and a biopsy forceps was used to determine how hard it was. This revealed that the polyp was elastically harder than an ordinary adenomatous polyp. Eventually, excisional biopsy of the polyp was performed by endoscopic mucosal resection rather than by snare polypectomy, and this procedure was uneventful. Histologically, the tumor was found to consist of adenoma arising from the mucosal layer, which showed transition to carcinoid tumor, mainly in the submucosal layer (Figure **2**). Because there was evidence of both lymphatic and venous invasion of tumor cells in the carcinoid component of the tumor, additional surgery was performed as a curative measure. No local residual tumor or lymph node metastasis was found.

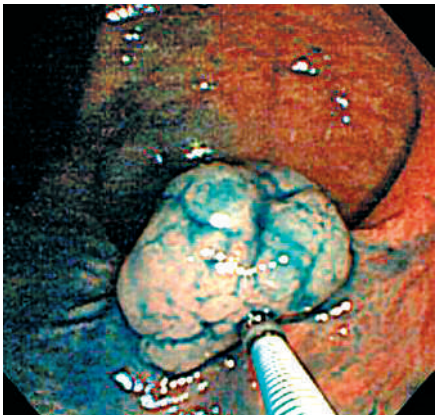

Figure **1** Colonoscopy revealed a tall but sessile polyp, 15 mm in diameter, in the middle part of the rectum. This polyp felt harder than an ordinary adenomatous polyp when examined using biopsy forceps.

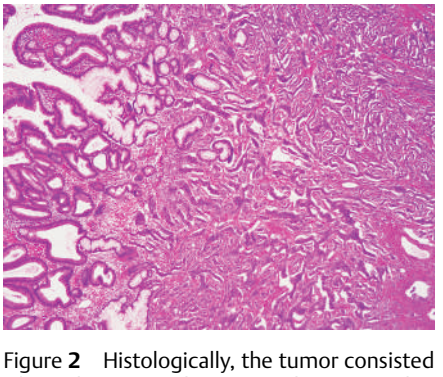

Figure **2** Histologically, the tumor consisted of an adenoma and a carcinoid tumor, with a transitional zone between them.

The term "composite adenoma-carcinoid tumor" has been used for tumors consisting of a glandular component (adenoma or adenocarcinoma) and a carcinoid component, particularly if there is evidence of a transitional zone between the two components [1]. It is extremely rare for the glandular component to be entirely benign [1–3]. The first such case was reported by Mori et al. in 1978 [2]. The presence of a transitional zone in this case supports the likely theory that the adenomatous component and the carcinoid element were derived from a common origin, and excluded the possibility of a "collision tumor". The endoscopic evidence of elastic hardness, as described above, provided a clue to the presence of a submucosal mass beneath the adenomatous polyp. Although not available in this case, endoscopic ultrasound is another option for evaluating this kind of tumor.

Endoscopy_UCTN_Code_CCL_1AD_2AB

Kuang-I Fu[1,2], Y. Sano[2], H. Kon[2], H. Ikematsu[2], Y. Kaji[1], T. Fujimori[3]

[1] Department of Radiology, Dokkyo University School of Medicine, Mibu, Shimotuga, Tochigi, Japan

[2] Division of Gastrointestinal Oncology and Digestive Endoscopy, National Cancer Center Hospital East, Kashiwa, Chiba, Japan

[3] Department of Surgical and Molecular Pathology, Dokkyo University School of Medicine, Mibu, Shimotuga, Tochigi, Japan.

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Corresponding Author

Kuang-I Fu, M.D., Ph.D.

Department of Radiology
Dokkyo University School of Medicine
880 Kitakobaysashi
Mibu
Shimotuga
Tochigi 321-0293
Japan
Fax: +81-282-86-5678
E-mail: fukuangi@hotmail.com

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