Localized giant pseudopolyposis of the colon (pseudopolyp larger than 1.5 cm in size) is a rare complication of inflammatory bowel disease. There is one report of an occult carcinoma within such a lesion, and no reports of sole dysplasia. A case of a 42-year-old man with longstanding Crohn's colitis who underwent a colonoscopy revealing a large, multilobulated mass at the splenic flexure that was not amenable to endoscopic removal, is described. Multiple biopsies showed no dysplasia and histology was consistent with an inflammatory pseudopolyp. Computed tomographic colonography demonstrated a mass resembling a large villous tumour. A decision for surgery was made. The surgical specimen was a complex anastomosing inflammatory pseudopolyp 5 cm × 4 cm × 3 cm in size, with a focus of low-grade dysplasia in an area free of inflammation. The present case is the first reported occult dysplasia in a giant pseudopolyp. Occult dysplasia without superficial dysplasia may exist in these lesions and further studies are needed to examine risk factors that make a giant pseudopolyp more likely to harbour dysplasia and/or carcinoma.

Key Words: Crohn's colitis; Dysplasia; Inflammatory; Occult; Pseudopolyph

Inflammatory polyps (pseudopolyps) are formed in the regenerative and healing phases of ulcerated epithelium and are deemed to have no intrinsic malignant potential (1,2). Localized giant pseudopolyposis of the colon is a rare complication of inflammatory bowel disease (IBD), defined as a pseudopolyp (isolated or clustered) larger than 1.5 cm (3,4). There are more than 75 reported cases in the literature (3-20), but only one report of an occult carcinoma associated with such a lesion (20) and no reports of associated dysplasia. A case of a giant pseudopolyp containing occult dysplasia in the absence of adenomatous tissue in a patient with Crohn’s colitis is presented.

CASE PRESENTATION

A 42-year-old man with longstanding Crohn’s colitis in remission, presented with a two-month history of nonbloody diarrhea. A colonoscopy revealed scattered diminutive pseudopolyps in the left colon and a large multilobulated mass at the splenic flexure that was not amenable to endoscopic resection. Biopsies revealed histology consistent with an inflammatory pseudopolyp. The patient was treated with oral antibiotics and mesalamine for active Crohn’s colitis.

A repeat colonoscopy three months later revealed few erosions; histology of the unchanged polyoid mass was again consistent with that of an inflammatory pseudopolyp. The patient underwent a barium enema, a spiral computed tomography scan and virtual computed tomography colonography, all of which demonstrated a mass suggestive of a large villous tumour.

A discussion with the patient considered the options of periodic surveillance versus surgery. Given the patient’s age (older than 40 years), his longstanding colitis, the polyp’s large size and its radiological features consistent with a villous tumour, surgery was performed.

The surgically resected specimen revealed a large, sessile, focally indurated polyp 5 cm × 4 cm × 3 cm in size, which was entirely submitted for histological examination (Figure 1). Under the microscope, the polyp was inflammatory and composed of confluent and complex anastomosing mucosal bridges, with mucosal chronic active inflammation and associated reactive epithelial atypia. The polyp also showed extensive scarring of the muscularis mucosae and submucosa, with numerous misplaced and trapped glands, characteristic of colitis cystica profunda that was focally transmural, accounting for the induration of the polyp. Its differentiation from an invasive, well-differentiated adenocarcinoma was particularly important given the finding of a focus of low-grade dysplasia. Indeed, in an...
Localized giant pseudopolyposis is a well-documented although uncommon occurrence in IBD (3-20). It has been described in both active and quiescent phases of disease, in all colonic segments and tends to occur early in the course of IBD (3,10-12). Clinical symptoms are not usually related to the lesion but rather to disease activity itself, although colonic obstruction and intussusception have been reported (16,19).

Clinically, endoscopically and radiologically, these masses have commonly been mistaken for neoplastic lesions (3,11,12,15,17,21). The dilemma revolves around confidently differentiating a giant pseudopolypl from a villous adenoma, dysplasia-associated lesion or mass, or polyoid carcinoma. The differential diagnosis also includes lymphoma and colitis cystica profunda (3,11,12).

Notwithstanding one report (20) of an occult malignancy arising in a giant pseudopolypl in ulcerative colitis, previous authors have suggested that colonoscopy with multiple biopsies will demonstrate the nature of the lesion and is considered sufficient to establish a diagnosis and avoid surgery (3,10,15-17). Surgery remains indicated for large lesions that are incompletely visualized or inadequately biopsied (3,11,15).

The first case of a giant pseudopolypl in Crohn’s colitis complicated by dysplasia is described. Importantly, the dysplasia was not identified on superficial endoscopic biopsy but rather in the surgical specimen. This suggests that the benign nature of these lesions should not be assumed. It remains unclear whether specific factors such as patient age, size of the lesion, or the duration or activity of the patient’s disease make a localized giant pseudopolypl more likely to harbour dysplasia. The natural history of these lesions, as well as their optimal management, remain uncertain. Radiological imaging can define the location and extent, but not the nature of these lesions. Until further data are available, when assessing giant pseudopolyplcs for occult dysplasia or adenocarcinoma, an individualized approach based on the patient’s disease characteristics, preferences and surgical candidacy is recommended.

**REFERENCES**
