

Title:

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Regression of a giant pseudopolyp in a patient with colonic Crohn's disease after therapy with infliximab

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ABSTRACT

Giant inflammatory pseudopolyps (> 15 mm) are an uncommon complication of inflammatory bowel disease (IBD) and a differential diagnosis with adenomas and carcinomas is challenging. Although usually asymptomatic, they may result in intestinal obstruction or intussusception due to their size. The standard management involves lesion biopsies and endoscopic excision for selected cases; surgery is usually reserved for size-associated complications or an uncertain pathology.

We report the case of a 43-year-old female patient with Crohn's disease (CD) in clinical remission, with no specific treatment at the time. A giant pseudopolyp of 40-mm was found during a screening colonoscopy. Therapy was initiated with infliximab and azathioprine in an attempt to reduce the size of the polyp and allow an endoscopic resection. Additional colonoscopies were performed following induction doses at

weeks 0, 2, and 6, which revealed a reduced lesion size. Mucosal resection was attempted but failed due to severe fibrosis, which prevented base injections from lifting up the polyp. However, a follow-up colonoscopy three months later showed that the lesion had completely disappeared. The evidence in the literature regarding giant pseudopolyp management is scarce, but reports indicate that they rarely disappear with medical therapy alone and usually require surgery or endoscopic resection.

Key words: Crohn's disease. Inflammatory pseudopolyp. Infliximab.

INTRODUCTION

Inflammatory pseudopolyps are non-neoplastic polypoid lesions arising from the intestinal mucosa. These occur due to repeated and prolonged periods of inflammation and ulceration associated with excessive healing, as in IBD. Some lesions may present as giant pseudopolyps (> 15 mm), casting doubt on a potential diagnosis of dysplasia or carcinoma (1). According to the literature, these lesions rarely respond to IBD-specific medical therapy and usually require endoscopic or even surgical resection (2).

CASE REPORT

We report the case of a 43-year-old female diagnosed with CD based on a sigmoidectomy specimen obtained due to suspected cancer. A screening colonoscopy eight years after diagnosis identified a 40-mm flat, polylobulated lesion reminiscent of a laterally spreading tumor of the granular type (LST-G) in the splenic flexure on a segment with minimal inflammatory changes (erythema, edema, aphthae). At the time, the patient was not under CD-specific treatment and was in clinical remission. Biopsies suggested an inflammatory pseudopolyp with no dysplastic findings. Computerized tomography (CT) revealed an endoluminal lesion in the splenic flexure with no evidence of extramural extension.

Due to the size of the lesion and the risk of degeneration, treatment was initiated with infliximab and azathioprine in an attempt to reduce the size and thus facilitate an endoscopic resection. Following induction doses of 5 mg/kg (350 mg), further colonoscopies were performed at weeks 0, 2, and 6, which revealed a reduced lesion.

A subsequent attempt at mucosal resection failed due to severe fibrosis, which precluded elevation after injecting the base of the mass. However, a follow-up colonoscopy after three months confirmed the complete disappearance of the lesion.

DISCUSSION

Giant inflammatory pseudopolyps are an uncommon complication of IBD (1,3). Their histological characteristics differ from those of adenomatous or hyperplastic polyps. These include deformed crypts lined with an epithelium with regenerative changes and a stroma where inflammatory cells and granulation tissue predominate, dysplasia is usually absent (4). Lesions are usually asymptomatic but may result in mechanical obstruction or intussusception due to their size (5-7). Their differential diagnosis with adenomas and carcinomas is challenging. Although giant pseudopolyps are considered to have no risk of malignant degeneration, both in and of themselves. Two cases have been reported with occult dysplasia and adenocarcinoma in patients with CD (1) and ulcerative colitis (UC), respectively (2). Clinical management usually involves lesion biopsies and endoscopic resection in selected cases; surgery is usually reserved for size-related complications such as obstruction, intussusception or an uncertain pathology (7). Furthermore, although pseudopolyps are benign lesions, their presence is an independent risk factor for malignancy as it reflects prior chronic inflammation (8).

Published data on the management of giant pseudopolyps are scarce but reports indicate that they rarely disappear with medical treatment and usually require surgical or endoscopic resection (2). Choi et al. reported two cases of giant pseudopolyp regression in patients with IBD following treatment with mesalazine and azathioprine (2). Liatsos et al. reported a case of infliximab-induced regression in a giant inflammatory pseudopolyp (9). Pilichos et al. also reported a giant pseudopolyp remission following a course of topical budesonide in a patient with UC (10). Thus, our case is the fourth report of a complete regression of a giant pseudopolyp after medical treatment with infliximab. Therefore, this drug should be established as first-line therapy, provided that the clinical status of the patient allows it.

CONCLUSION

Conservative drug therapy is an option to consider for the management of giant pseudopolyps in the IBD setting. We conclude that medical treatment with immunosuppressants and/or biologics may be a first-line option for patients with few or no symptoms, whereas endoscopic mucosal resection or surgery can be set aside for acute emergency presentations such as bleeding or bowel obstruction.

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Fig. 1. Inflammatory pseudopolyp in the splenic flexure.

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Fig. 2. Inflammatory pseudopolyp in the splenic flexure.

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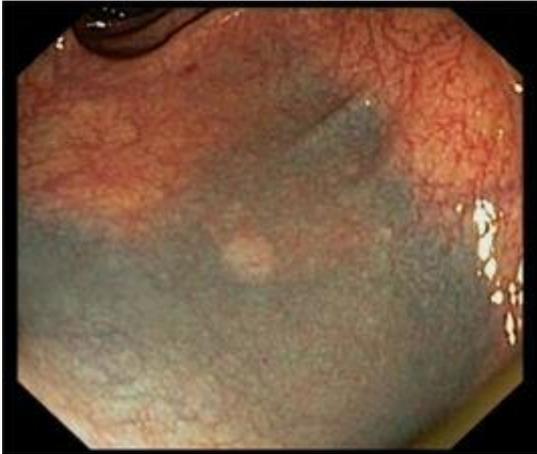


Fig. 3. Splenic flexure in the last colonoscopy, showing the disappearance of the pseudopolyp.

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