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Endoscopic mucosal resection for cap poliposis treatment

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Dear Editor,

We report the case of a 39-year-old male patient who presented with a several month history of rectal bleeding, mucous diarrhea and tenesmus and no other relevant medical history. Colonoscopy identified a multinodular rectal lesion (Paris 0-Is+IIa) with an erythematous and friable mucosae covered with a fibrinous exudate. Biopsies taken for viral and bacterial cultures were negative and the histological evaluation revealed changes suggestive of inflammatory polyps and malignancy was ruled out. Based on the endoscopic and histological findings and after ruling out an infectious etiology, the diagnosis of cap-polyposis was suspected. After the failure of *H. pylori* eradication treatment, an endoscopic resection of the lesion was performed. Piecemeal endoscopic mucosal resection (pEMR) was performed and argon plasma coagulation was used to complete the pEMR. The histological analysis showed a colic mucosa with granulation tissue, fibrinoleukocytic material and hyperplastic dilated crypts, which confirmed the diagnosis of cap polyposis. One year after pEMR, the patient remained asymptomatic and the follow-up colonoscopy showed a polypectomy scar, which had a smaller size and fibrous appearance without erythema or bleeding tendency.

Discussion

Cap polyposis is a benign inflammatory condition that can affect any people of any age with a female predominance (1-3). It is characterized by inflammatory polyps covered by a fibrinopurulent exudate and usually involves the rectum and sigmoid colon (4). Mucous diarrhea and rectal bleeding are frequent symptoms. The histopathology is typical, with "cap" granulation tissue that provides its characteristic appearance (4). It has been related to mucosal prolapse syndrome and *H. pylori* infection (2,3). The optimal treatment has not been established due to an unknown pathogenesis and a variable clinical course. Medical treatment must be the first option by resolving constipation, eradication of *H. pylori* and, in case of no improvement, resection of the lesions can be considered (4,5). In our case, we decided to perform a pEMR completed with argon plasma coagulation *versus* endoscopic submucosal dissection or surgical resection due to the lower rate of complications and the shorter procedure time.

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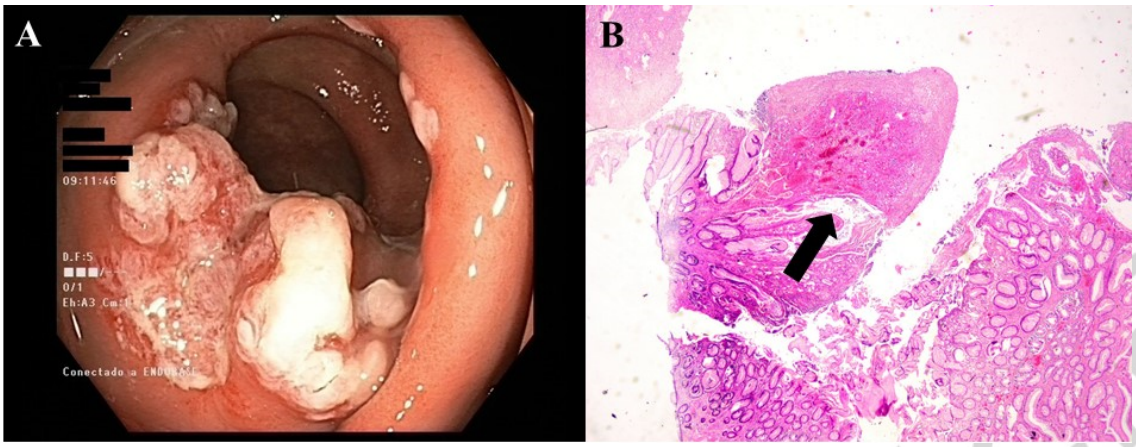

Fig. 1. A. Multinodular rectal lesion Paris 0-Is+0-IIa between 6-10 cm from anal verge, with an erythematous and friable mucosae and covered by a fibrinous exudate. B. A cap of fibrin and necroinflammatory exudate with congestive granulation tissue covers a colorectal mucosa with hyperplastic and tortuous crypts H&E (10x). Arrow points at the necroinflammatory cap.