Inflammatory Fibroid Polyp of the Cecum can be Treated by Endoscopic Resection

Sir,

An inflammatory fibroid polyp (IFP) is a rare benign, nonneoplastic, polypoid lesion of the gastrointestinal tract. A 66-year-old hypertensive and diabetic woman was referred to us for the evaluation of severe iron deficiency anemia. Clinically she was obese, pale, with stable vital signs, and physical examination revealed no abnormalities. Laboratory data were unremarkable except for a hemoglobin level of 62 g/L; upper endoscopy was normal.

Colonoscopy revealed a 3-cm sessile, polypoid lesion in the cecum, and biopsy was performed [Figure 1]. A CT scan of the abdomen was normal except for small pericecal lymph nodes. Histology of the polypoidal lesion showed features of an inflammatory fibroid polyp. The patient underwent a second colonoscopy and the polyp was removed using the snare-and-cautery technique without any complications, in small pieces. But at the end the whole polyp was removed leaving only its base.

Microscopically, the lesion was a polypoidal mass of fibromuscular and inflammatory tissue covered by colonic mucosa. The latter was continuous with the underlying tissue and had focal ulceration and granulation tissue formation. The lesion was composed of a highly vascular tissue with bland fibroblast-like cells and an inflammatory infiltrate of lymphocytes, eosinophils, and plasma cells. In some areas, the inflammation was dense with the formation of reactive lymphoid follicles [Figure 1].

Colonic IFP is rare and there have only been a total of 44 cases, including our case, reported in the literature.[1-3] Out of 26 cases of colonic IFP reported by Sakamoto et al., 17 have been treated surgically. Different techniques have been described for the endoscopic removal of the polyp including the one using the clip-and-cut technique.[4]

In our case, a large polypoid lesion was found in the cecum during colonoscopy done as a part of the diagnostic work-up for iron deficiency anemia. IFPs originate primarily in the mucosa and submucosa, but they can, in rare instances, extend to the muscular layer. In this patient, the IFP was predominantly in the mucosa without any extension to the muscular layer, and hence, we decided to remove this by colonoscopy and the snare polypectomy technique. Follow-up colonoscopies done three months and a year later showed no residual lesions or recurrence.

As the IFP is a benign polyp and its recurrence is very rare, we believe that its endoscopic removal is an appropriate treatment modality. With wide use of colonoscopy, more such cases of IFP will probably be identified, and awareness of such condition among physicians will help to avoid surgery and resection.

Musthafa Chalikandy Peedikayil, Hindi N. Al Hindi, Mohamed Awad Said Rezeig

1,3Department of Medicine (MBC 46), Section of gastroenterology, King Faisal Specialist Hospital and Research Center, 2Department of Pathology and Laboratory Medicine, Riyadh, Saudi Arabia. E-mail: musthafa.cpdr@gmail.com
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Gall Bladder Perforation as a Complication of Typhoid Fever

Sir,

Among various described complications of typhoid fever, acute cholecystitis is a rare one,[1] while perforation of the gallbladder is extremely uncommon. We share our experience of gall bladder perforation—this rare complication of typhoid. A 10-year-old boy presented to us with fever of 10 days' duration, distension of the abdomen, and an inability to pass flatus and feces for two days. Clinical examination demonstrated the presence of guarding, rigidity, and rebound tenderness. An X-ray of the abdomen showed multiple air fluid levels, but no free air. The Widal test was strongly positive for Salmonella typhi ‘O’ and S. typhi ‘H’ but negative for S. paratyphi.

After initial resuscitation, the patient was operated; exploratory laparotomy revealed a bile-stained abdomen with matted bowel loops. There was no bowel perforation, but a large perforation in its fundus was noticed on exploring the gall bladder. Cholecystectomy was performed; the postoperative period was uneventful, and the patient was discharged on the 10th postoperative day.

Acute cholecystitis is a rare complication of typhoid,[1] presenting mostly in the first week of illness. Characteristic findings include fever, abdominal pain, diarrhea, vomiting, jaundice, and a palpable mass.[1] The clinical features suggestive of gall bladder perforation are nonspecific. Paracentesis may reveal bile-stained ascitic fluid.[2] Abdominal X-rays may not show pneumoperitoneum as seen in our patient, and hence, they are not always helpful. Ultrasonography and computerized tomography may demonstrate abdominal fluid but lack specificity to diagnose gall bladder perforation, which can be easily detected on hepatobiliary scanning.[3] A high index of suspicion is needed to diagnose the condition. Surgical options include cholecystostomy or cholecystectomy.[1] However, we believe that cholecystectomy may be desirable to prevent the carrier state of typhoid fever.

Perforation of the gall bladder may be caused by an inflammatory reaction and weakness of its wall in the course of the disease. Histology shows inflammatory changes in the gall bladder[2] that were also noticed in our patient.

Gall bladder perforation after typhoid cholecystitis is an uncommon occurrence in a pediatric population. A simple literature search revealed fewer than 10 cases in children, and all these reports were very old.

Gall bladder perforation in the setting of typhoid requires a high degree of clinical suspicion, especially in the pediatric population. Hence, surgeons must bear in mind the possibility of this complication while treating any pediatric patient presenting with a history of prolonged fever and signs of peritonitis. Cholecystectomy is the treatment of choice with a reasonable outcome.

Anand Pandey, Ajay N. Gangopadhyay, Vijayendra Kumar

Department of Pediatric Surgery, Institute of Medical Sciences, Banaras Hindu University, Varanasi-221 005, U.P., India.

E-mail: gangulybhu@rediffmail.com

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