

A giant villous adenoma case mimicking right colon carcinoma

Sağ kolon kanserini taklit eden dev villöz adenoma

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An 85-year-old woman was admitted to our hospital due to pain and swelling in her right inguinal region. She had a right inguinal hernia. Abdominal computerized tomography revealed an 8x8 cm cecal mass and also a 13.5 cm segmental asymmetric nodular thickening of the cecum. Colonoscopic examination revealed a sessile polypoid mucus-secreting mass mimicking carcinoma that narrowed the cecal lumen. Histopathological examinations of sections from colonoscopic biopsy materials on light microscopy revealed villous adenoma morphology. The patient underwent operation, and an 18x6x4 cm mass, which partially obstructed the cecum, was seen. A right hemicolectomy was performed for complete excision. Histopathological examination revealed a pure villous adenoma, and there was no sign of malignant degeneration. On the 6th postoperative day, the patient was discharged from the hospital. During follow-ups at three-month intervals throughout one year, no abnormal colonoscopic or laboratory findings were assessed. We believe that, in older patients with inguinal hernia, presence of intraabdominal mass should be considered. Furthermore, we showed in this report that villous adenomas can reach significant dimensions without causing any protruding signs or electrolyte imbalance and can mimic colon carcinoma.

Seksenbeş yaşında bayan hasta sağ alt kadranda ağrı ve şişlik yakınmasıyla başvurdu. Ayrıca sağ inguinal hernisi de mevcuttu. Abdominal tomografide çekum ve terminal ileumda yaklaşık 13,5 cm'lik bir segmentte asimetric nodüler duvar kalınlaşması saptandı. Kolonoskopide, çekumda lümeni ileri derecede daraltan, üzerinde yoğun mukus salgısı içeren polipoid lezyon saptandı. Kolonoskopi sırasında alınan multiple biopsilerin patolojik incelemesinde villöz adenom morfolojisi görüldü, malignite saptanmadı. Endoskopik polipektominin mümkün olmadığı hasta ameliyat edildi. Sağ kolonda çekum üzerinde 18x6x4 cm boyutlarında sert kitle görüldü ve hastaya sağ hemikolektomi yapıldı. Patolojik incelemesinde villöz adenom dışında başka patolojik bulguya rastlanmadı. Bir yıllık izleminde sübjektifyakınması olmayan hastanın kontrol kolonoskopik incelemelerinde patolojik bulguya rastlanmadı. Sonuç olarak, inguinal herni nedeniyle başvuran ileri yaş hastalar, intraabdominal yer işgal eden lezyonlar yönünden dikkatli araştırılmalıdır. Bununla birlikte villöz adenomlar, elektrolit dengesizliğine neden olmaksızın, parsiyel obstrüksiyona neden olacak kadar büyük boyutlara ulaşabilir ve kolon kanserini taklit edebilir.

Key words: Villous adenoma, carcinoma, colon

Anahtar kelimeler: Villöz adenom, karsinom, kolon

INTRODUCTION

Colorectal polypoid lesions have a risk for cancer development. Because of their malignancy potential and indistinguishable features from carcinoma at the diagnosis, they should be either excised or submitted for biopsy to assess further intervention. Adenomatous polyps are the most common type among other colorectal polyps. There are three common histopathological types of colorectal adenomatous polyps, namely tubular (67%),

villous (5%) and tubulovillous (8%). Among them, villous adenomatous polyps have the greatest potential for cancer development (1). Also, villous adenomas, because of their secretory activity, can cause diarrhea and electrolyte imbalance (1-4). In this report, we present a patient with giant villous adenoma which did not cause intestinal obstruction or any electrolyte imbalance.

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CASE REPORT

An 85-year-old woman was admitted to our hospital due to pain and swelling in her right inguinal region. She also gave the history of an operation for right inguinal hernia six years previously. On physical examination (PE), a minimal abdominal distention and tenderness of the right inguinal region, especially on the previous inguinal incision scar, were observed; a mobile mass was also palpated. Bowel sounds were normoactive on auscultation. Abdominal computerized tomography (CT) revealed an 8x8 cm cecal mass together with a 13.5 cm segmental asymmetric nodular thickening of the cecum (Figure 1a, 1b). On colonoscopic examination, multiple diverticula in sigmoid colon, left colon and splenic flexura were seen. A giant sessile polypoid mucus-secreting mass that narrowed the cecal lumen was also demonstrated. Histopathological examinations of sections from colonoscopic biopsy materials on light microscopy (LM) revealed villous adenoma morphology.

Clinical course

As the lesion could not be excised by endoscopy, the patient underwent operation. An 18x6x4 cm mass in the cecum was observed; the appendix was normal. Although the lesion had a malignant appearance and significant dimensions, there was no sign of obstruction in intestinal segments proximal to the lesion. Therefore, a right hemicolectomy was performed for complete excision. The macroscopic appearance seemed to be a carcinoma originating from a polypoid lesion in the cecum (Figure 2a, 2b).

Histopathological examination of the lesion revealed long finger-like fronds lined by neoplastic

epithelium and low-grade dysplasia in the epithelium (Figure 3a, 3b). There was no evidence of metastatic carcinoma in the dissected lymph nodi. Pathological diagnosis was a pure villous adenoma, and there was no sign of malignant degeneration.

On the 6th postoperative day, the patient was discharged from the hospital. During routine follow-ups at three-month intervals throughout one year, no abnormal colonoscopic or laboratory findings were assessed.

DISCUSSION

Colonoscopy has the great advantage of early diagnosis of precancerous colonic lesions, including adenomatous polyps. Adenomatous polypoid lesions may occur anywhere throughout the colonic mucosa. Compared to the incidence rates in other portions of the colon, they are rarely seen in the cecum (8%) (3, 4). They may be broad-based or pedunculated and vary in size and may cause obstruction. Interestingly, even though the polypoid lesion in our case reached obstruction size, it did not cause any clinical sign that might be related to intestinal obstruction. Also of interest is that the major complaint of our patient was swelling and recurrent hernia of the right inguinal region.

Inguinal hernia may occur at any age. However, it is important to recall that any pathologic condition that causes increased intraabdominal pressure may cause an inguinal hernia. In our clinic, to rule out any neoplastic lesion, we routinely use ultrasonography and, if necessary, abdominal CT in older patients with inguinal hernia.

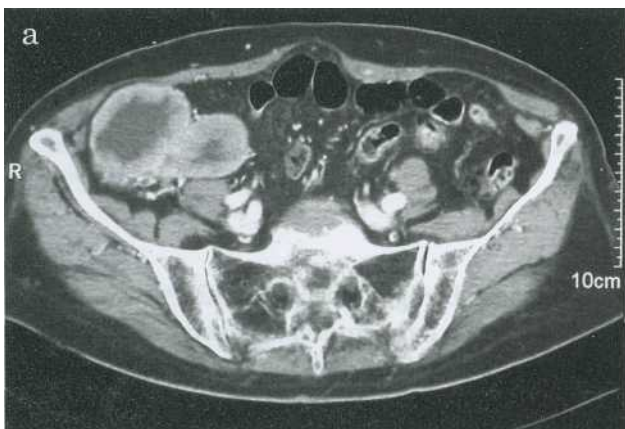


Figure 1: a) Abdominal computerized tomography (CT) finding that revealed cecal wall thickness



Figure 1: b) Cecal mass and cecal wall asymmetry in another CT section



Figure 2: a) Macroscopic appearance of the right hemicolectomy material (note appendix lumen adjacent to the mass)



Figure 2: b) Appearance of the mass from another aspect - normal terminal ileum mucosal fold is seen

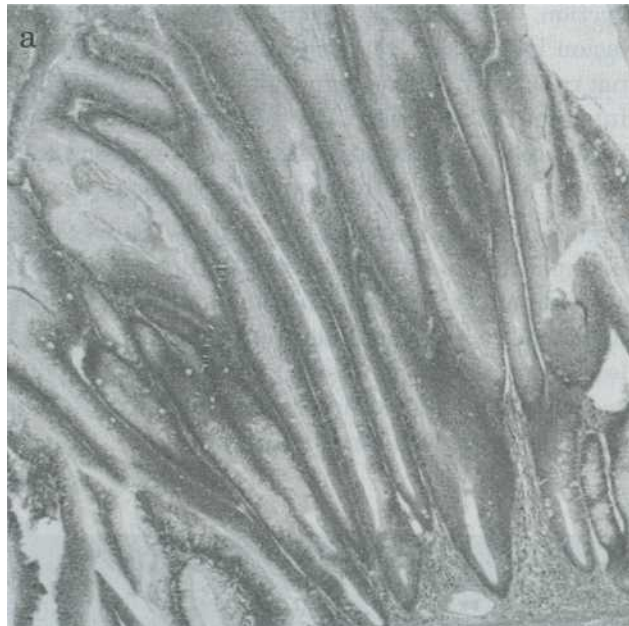


Figure 3: a) Macroscopic appearance of the right hemicolectomy material (note appendix lumen adjacent to the mass)

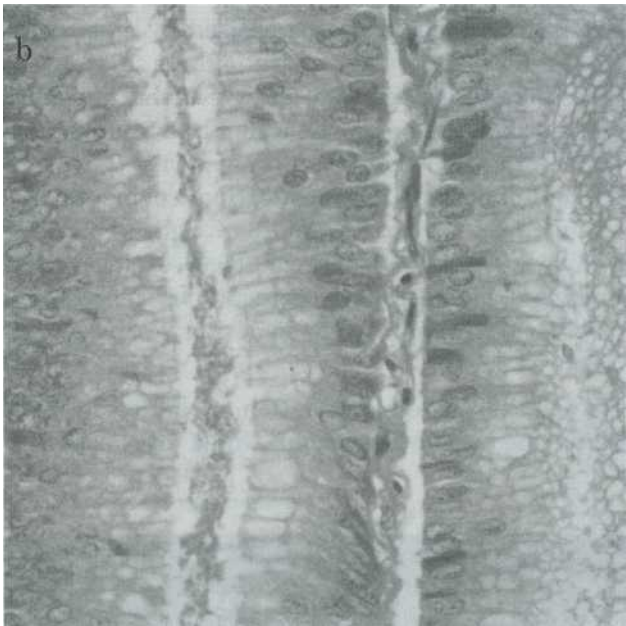


Figure 3: b) Appearance of the mass from another aspect - normal terminal ileum mucosal fold is seen

Villous adenoma may cause two important complications, namely obstruction and electrolyte imbalance. In our case, villous adenoma did not cause electrolyte imbalance or intestinal obstruction, despite its macroscopic appearance and significant dimensions. In addition to its complete his-

topathologic benign nature on LM examination, these were the most interesting aspects of the present case. These features of our case are not in line with previous reports (5-7).

There are some reports in the literature that indicate that local giant polyposis occurs as a consequ-

ence of chronic inflammatory bowel disease (1, 3, 8). Also, giant pseudopolyposis occurring in 10%-20% of ulcerative colitis cases mimics villous adenoma (9, 10). However, in our case, histopathological examination of the lesion did not reveal any sign of inflammatory bowel disease.

In conclusion, we believe that in older patients with inguinal hernia, presence of an intraabdominal mass should be considered. Also, villous adenomas may reach significant dimensions without causing any signs of obstruction or electrolyte imbalance and they may mimic colon carcinoma.

REFERENCES

1. Bauknecht KJ, Grosse G, Kleinert J, et al. Filiform polypoidosis of the colon in chronic inflammatory bowel disease (so-called giant inflammatory polyps). *Z Gastroenterol* 2000; 38: 845-54.
2. Jatzko G, Siebert F, Wolf B, et al. Combined restorative proctocolectomy and pancreaticoduodenectomy for familial adenomatous polyposis. *Z Gastroenterol*. 1999; 37: 1109-13.
3. Salahi I, Tevlin W, Jawny L, et al. Giant hyper-secreting villous adenoma of the rectum. *J Med Soc N J* 1979; 76: 35-8.
4. Cook JM, MacLennan JC. Giant villous adenoma of the rectum with severe electrolyte imbalance. *W V Med J* 1969; 65: 328-9.
5. Murata I, Kume K, Yoshikawa I, et al. Localized giant pseudopolypoidosis of the colon in ulcerative colitis: use of the magnifying endoscope. *Gastrointest Endosc* 1999; 50: 869-71.
6. Nozoe T, Matsumata T, Sugimachi K. Carcinoma in villous adenoma of ascending colon associated with sarcoid reaction in the regional lymph nodes. *J Clin Gastroenterol* 1999; 28: 377-9.
7. Abolhoda AM, Yelcick JM, Swan KG. Pancreatoduodenectomy for giant benign villous adenoma of the ampulla of Vater. *Am Surg* 1997; 63: 392-4.
8. Braga M, Stella M, Zerbi A, et al. Giant villous adenoma of the duodenum. *Br J Surg* 1986; 73: 924.
9. Kovalcik PJ, Szydlowski TR. Localized giant pseudopolypoidosis of the colon in ulcerative colitis. *Dis Colon Rectum* 1980; 23: 268-70.
10. Teague RH, Read AE. Polyposis in ulcerative colitis. *Gut* 1975; 16: 792-5.