Turk J Gastroenterol 2007; 18 (3): 206-207

LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
Colitis cystica profunda

Kolitis sistika profunda

To the Editor

Colitis cystica profunda (CCP) is a rare entity with unknown etiology. It is associated with specific histological changes and abnormal defecation with passage of blood and mucus and anorectal discomfort (1, 2). There are approximately 200 documented cases in the literature. Colorectal involvement is referred to as CCP, while small intestinal involvement is termed "enteritis cystica profunda" (ECP) (1, 3, 4).

A 44-year-old man was admitted with rectal bleeding, mucus discharge, tenesmus, rectal incontinence, and prolapse for 18 months. Aside from complete rectal prolapse that occurred with severe squeezing, his physical examination was normal. Laboratory studies were normal except for mild iron deficiency anemia and leukocytosis.

Edematous and fragile mucosa and multiple white-grey 5-7 mm polypoid lesions were observed in rectum with colonoscopy (Figure 1); the remaining colon was normal. Histologically, there were multiple cysts in the muscularis mucosa filled with mucin. Cysts were coated with columnar epithelium and were surrounded by fibrous tissue and inflammatory infiltrate.

Transrectal ultrasonography and pelvic magnetic resonance imaging (MRI) revealed multiple cysts in the rectal mucosa. The patient was then consulted with gastrointestinal surgery and low anterior resection with colo-anal anastomosis was performed (Figure 2). Pathological investigation of specimen confirmed the diagnosis. All complaints of the patient resolved completely after surgery.

Colitis cystica profunda is a benign disorder characterized by mucin-filled cysts located deep in the muscularis mucosa (1). Cysts are frequently encountered in the colon and anterior rectal wall (2-6). Chronic inflammation and trauma are common features (5), which may result from inflammatory bowel disease (IBD), ischemia, internal intussusception, rectal prolapse, and direct digital trauma. Other conditions associated with CCP include solitary rectal ulcer syndrome, Peutz–Jeghers syndrome, irradiation, and rarely IBD (1-3, 6).

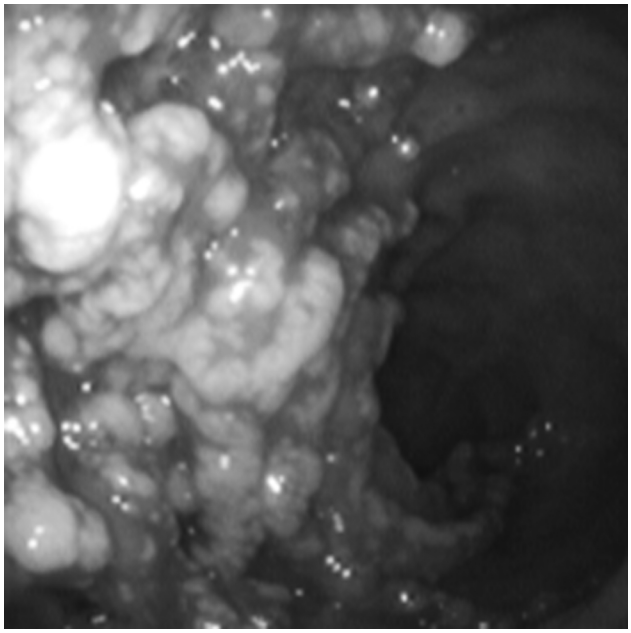

Figure 1. Colonoscopic appearance of rectal lesions. There were multiple, white-grey nodules, 5–7 mm in diameter, in rectum and in rectosigmoid junction. There was no mucosal ulcer. The mucosa surrounding the polyps was edematous and fragile

Endoscopy and barium studies may reveal the lesions (7). Endoluminal ultrasound may identify

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Manuscript received: 19.04.2006 **Accepted:** 12.07.2007

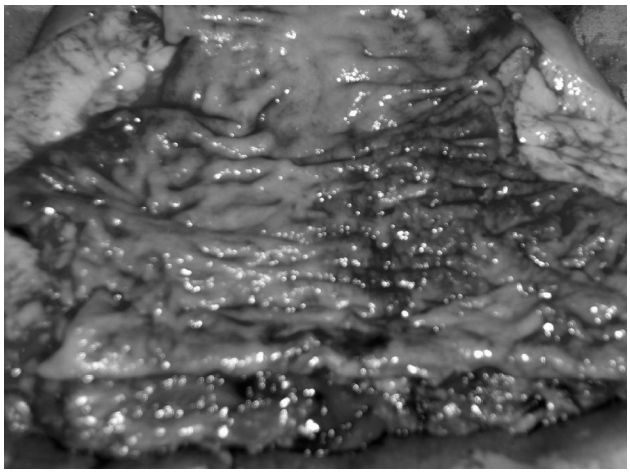

Figure 2. Macroscopic evaluation of resected surgical specimen. Rectal prolapse was observed preoperatively. There were multiple nodular and polypoid lesions in the rectum, and the surrounding mucosa was edematous and fragile. Beyond recto-sigmoid junction, colonic mucosa was completely normal

cysts in the rectal wall. Computerized tomography (CT) scan or MRI reveals noninfiltrating submucosal masses, loss of perirectal fatty tissue, and thickening of levator ani muscles (2). Defecography documents intussusception in 45-80% of patients.

Management should begin with diet and lifestyle changes. Patients are instructed to avoid straining in defecation. Biofeedback therapy may be successful (7). Pharmacological therapy includes lubricants, bulking laxatives, hydrocortisone enemas, and sucralfate (5).

Patients with persistent symptoms may be considered for surgery. Transanal excision to a major resection with colo-anal pull-through is offered to patients without prolapse (3). Patients with prolapse may be offered proctectomy (mucosal or perineal) or abdominal procedures (fixation or resection and rectopexy) (3, 4).

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