5. Kobayashi E, Kawai A, Seki K, et al. Bilateral adrenal gland metastasis from malignant fibrous histiocytoma: value of [F-18]FDG PET-CT for diagnosis of occult metastases. Ann Nucl Med 2006; 20: 695-8.
6. Lucas JD, O'Doherty MJ, Cronin BF, et al. Prospective evaluation of soft tissue masses and sarcomas using fluorodeoxyglucose positron emission tomography. Br J Surg 1999; 86: 550-6.
7. Bucerius J, Buchholz B, Strunk H, et al. Avoidance of invasive diagnostic and harmful therapeutic measures in a patient with malignant fibrous histiocytoma and extensive clinically occult metastases. J Natl Med Assoc 2009; 101: 953-5.

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Low rectal mass diagnosed as a cap polyp

Şapka polibi tanısı alan rektal kitle vakası

To the Editor,

Cap polyposis is a rare disease, reported occasionally in case series. We report here a case of a mass-forming low rectal lesion diagnosed as a cap polyp, which resolved spontaneously after the lesion was partially removed by snare. This type of case has not been reported previously.

A 31-year-old man was admitted to our hospital with a history of frequent mucous and bloody diarrhea (>10 times/day) and tenesmus that had persisted for six months. He had no significant medical or sexual history, and was not taking any medications. Laboratory tests including stool exam disclosed no abnormalities. Colonoscopy revealed multiple (>10) reddened and eroded sessile polyps with nonspecific intervening mucosa, which were consistent with the features of cap polyps, in the distal sigmoid colon (Figure 1). On a retroflexed view of the rectum, a large mass of more than 4 cm immediately above the dentate line was also observed, and the characteristics seemed similar to those of the one in the sigmoid colon. A partial endoscopic resection with hot snare was attempted for accurate diagnosis and treatment. On the histological examination of the mass, the patient was diagnosed as cap polyp without malignant cells (Figure 2).

After resection, the main symptoms improved dramatically. A year later, colonoscopy demonstrated

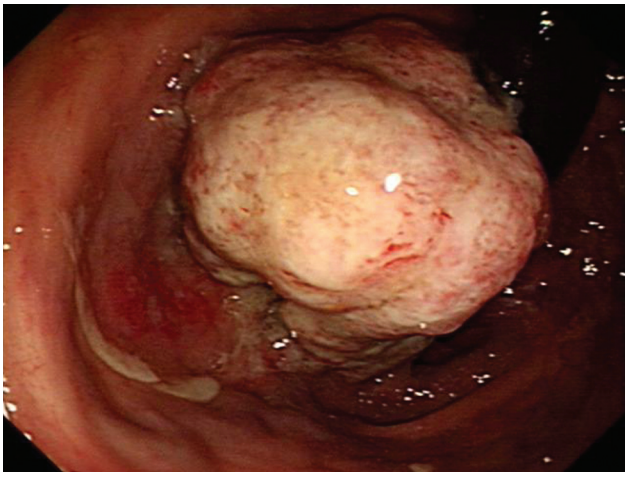

Figure 1. Colonoscopic view of cap polyps in sigmoid colon and around the anus shows a large mass with coarse surface and copious exudates before.

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disappearance of the mass with no pharmacotherapy due to follow-up loss, and a decrease in the number of polyps in the sigmoid colon. To date, the patient exhibits no particular symptoms and is being followed on an outpatient basis.

Cap polyposis is a rare disease; only 20-plus cases have been reported since the first report by Williams et al. (1) in 1985 (2,5,6). Its main symptom is mucoid, bloody diarrhea. It usually involves the rectum and sigmoid colon, and histologically is characterized by a cap of fibrinopurulent exudate (7).

The pathogenesis of cap polyposis is not known accurately yet, but one cause seems to be repeated trauma to the colonic mucosa from abnormal colonic movements and straining during defecation (4).

In this case, the lesion was difficult to differentiate from a malignant tumor by colonoscopy alone, and we thus attempted a partial resection. The reason for partial resection is that the mass was so large that complete resection posed a high risk of complications during the procedure, and histological diagnosis was given a high priority because the shape of the mass was similar to those found in the sigmoid colon.

Various methods of managing cap polyposis have been attempted, including conservative treatment, drug treatment, endoscopic resection, and surgical excision (3). However, a clear-cut therapy has yet to be identified.

In conclusion, we report an interesting case of cap polyp presenting as a large mass on retroflexed view in the rectum, not described previously in the literature, and cured by a combination of partial resection and subsequent conservative management.

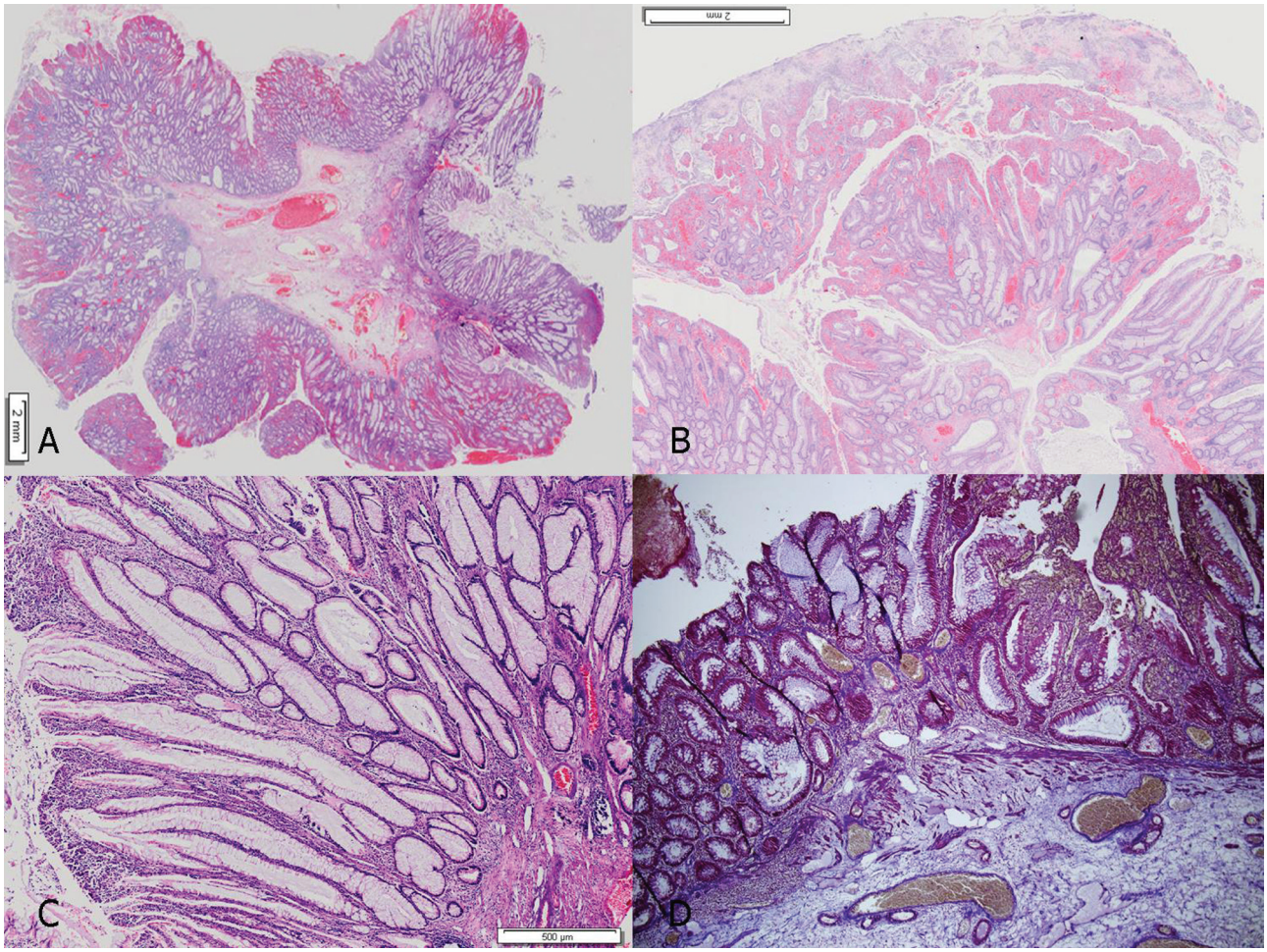

Figure 2. Histological view of the resected specimen from the perianal mass. A mucosal surface exudates by a "cap" of mucoid and fibrinopurulent exudates with hyperplastic change and regenerative atypia.

REFERENCES

1. Williams GT, Bussey HJ, Morson BC. Inflammatory 'cap' polyps of the large intestine. Br J Surg 1985; 72: S133.
2. Ng KH, Mathur P, Kumarasinghe MP, et al. Cap polyposis: further experience and review. Dis Colon Rectum 2004; 47: 1208-15.
3. Bookman ID, Redston MS, Greenberg GR. Successful treatment of cap polyposis with infliximab. Gastroenterology 2004; 126: 1868-71.
4. Tomiyama R, Kinjo F, Kinjo N, et al. Gastrointestinal: cap polyposis. J Gastroenterol Hepatol 2003; 18: 741.
5. Maunoury V, Breisse M, Desreumaux P, et al. Infliximab failure in cap polyposis. Gut 2005; 54: 313-4.
6. Konishi T, Watanabe T, Takei Y, et al. Cap polyposis: an inflammatory disorder or a spectrum of mucosal prolapse syndrome? Gut 2005; 54: 1342-3.
7. Oshitani N, Moriyama Y, Matsumoto T, et al. Protein-losing enteropathy from cap polyposis. Lancet 1995; 346: 1567.

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A rare case of primary systemic amyloidosis presenting with hepatic failure

Hepatik yetmezlik ile gelen primer sistemik amiloidoz

To the Editor,

Amyloidosis is a disease characterized by the deposition of altered proteins in tissues. Amyloidosis is classified as primary or secondary disease. Hepatic involvement, secondary amyloidosis is common, but primary systemic amyloidosis (amyloid light [AL] chain) is an uncommon entity (1). It may result in massive hepatomegaly, elevated serum alkaline phosphatase (ALP) levels and rapidly progressive liver failure (2).

A 51-year-old male presented with nausea, vomiting and jaundice. Hepatomegaly and ascites were noted on physical examination. Laboratory tests revealed the following values; WBC: 13200/mm^3, Hct: %36, Plt: 487000/mm^3, PT: 16.7 sn, INR: 1.48, APTT: 40.7 sn, ALT: 45 U/L, AST: 69 U/L, ALP: 235 U/L, GGT: 255 U/L, LDH: 186 U/L, T. Bilirubin: 24 mg /dL, D. Biluribin: 17 mg/dL, Albumin: 2.3 g/dL, Ca: 12 mg/ dL. Protein electrophoresis revealed polyclonal hyper-gammopathy. Serum and urine kappa and lambda light chain levels were elevated. Roller formation on peripheral smear was observed and plasma cells were increased (6%). Markers for hepatitis and autoimmunity were negative. Abdominal tomography showed hepatomegaly, blunt contours and homogeneous parenchyma on liver. Endoscopic retrograde cholangiopancreatography (ERCP) revealed normal gall tracts. Examination of abdominal ascites showed characteristics of transudate. Space of Disse, pa-

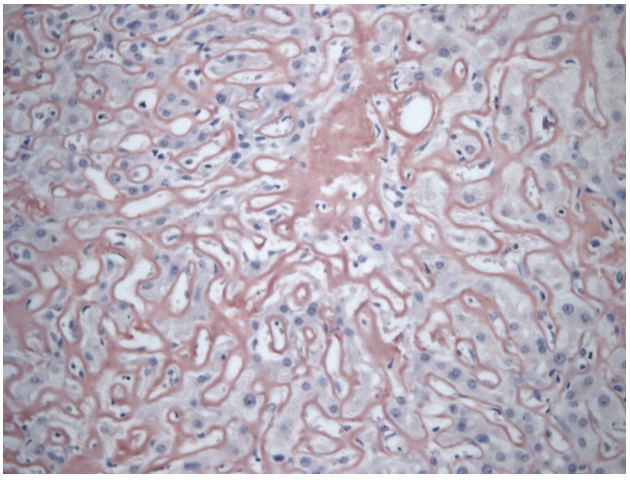

Figure 1. The pathologic specimen revealing: liver biopsy staining with Congo red and non-staining with potassium permanganate.

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