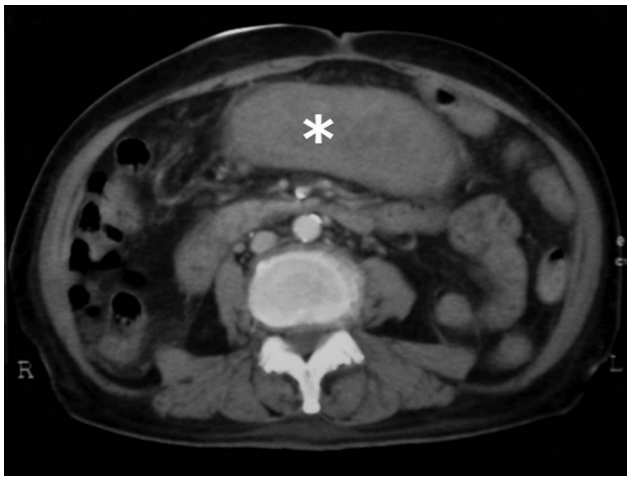

**Figure 1.** Axial CT image shows a large intramural hematoma in the stomach (asterisk).

sistent with gastric antral vascular ectasia (GAVE). The hematoma resolved but she continued to have recurrent anemia requiring intermittent blood transfusion since she continued to decline any endoscopic therapies.

Clinically significant bleeding is estimated to occur in less than 0.5% of all cold mucosal biopsies (1,3). Clinically significant gastric bleeding after biopsy is limited to case reports (1,2). The risk factors are probably similar regardless of the part of the gastrointestinal tract and include coagulopathy, thrombocytopenia, and vascular or mucosal abnormalities such as ulcerations. Bleeding occurs as a result of submucosal vessel injury caused by forceps biopsies (4). In intramural bleeding, treatment is mainly conservative with blood, platelets and fresh frozen plasma transfusions and acid suppressions. Embolization therapy has been reported to be successful (5). Finally, surgery should be considered if bleeding is not controlled with the other measures.

In conclusion, our case highlighted a rare but potentially fatal complication of a routine procedure. It is important for clinicians to be aware of intramural hematoma and to consider it in patients who undergo endoscopy and routine mucosal biopsies.

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# Giant fibroepithelial polyp of the anus

*Anüsün dev fibroepitelyal polibi*

*To the Editor,*

Fibroepithelial polyps of the anus, also known as hypertrophied anal papillae, are benign polypoid structures formed by the anal squamous epithelium and the subepithelial connective tissue. They are generally small and asymptomatic (1). To the present, giant fibroepithelial polyp of the anus has


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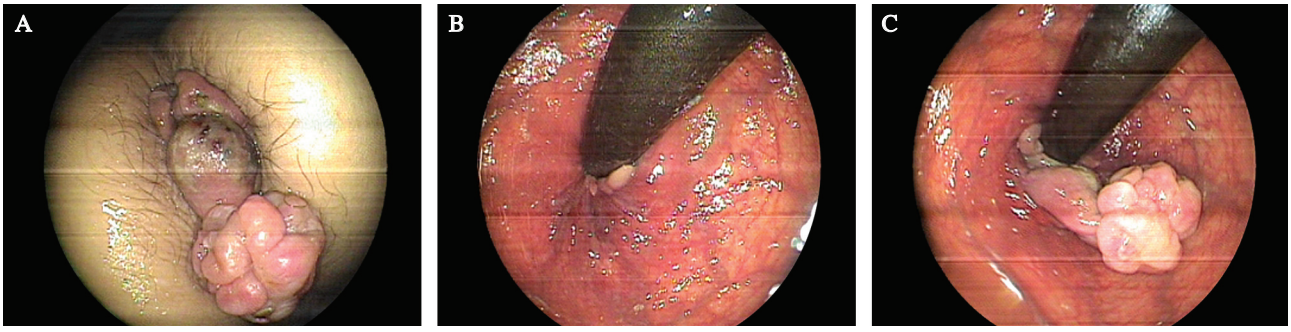


**Figure 1.** Appearances of the giant fibroepithelial anal polyp. **A:** External appearance. **B:** Endoscopic appearance in retroflex position. **C:** Endoscopic appearance after the mass was repositioned into the rectum.

been reported rarely in the medical literature. To the best of our knowledge, this is only the third case report. Herein, we present a case of giant fibroepithelial polyp of the anus.

A 54-year-old female patient was admitted to our outpatient clinic with persistent perianal pain, foreign body sensation and discomfort while sitting over the last 20 years. She had previously sought medical treatment for hemorrhoids over the years. On admission, anal examination showed a giant lobulated mass prolapsed out of the rectum and attached to a pedicle extending over the posterolateral wall of the anal canal. On digital examination, the mass was repositioned into the rectum. This lesion was located under the dentate line at rectoscopy (Figure 1). Laboratory tests for complete blood count, serum kidney and liver functions, and tumor markers were normal. The mass was excised on surgical operation. The histological findings of the lesion revealed the diagnosis of fibroepithelial polyp of the anus (Figure 2).

These polyps may have the appearance of hemorrhoids. They can be treated incorrectly as hemorrhoids. Therefore, fibroepithelial anal polyp, in spite of its size, should be considered in the differential diagnosis of a mass located near the anal verge and in patients with persistent anal symptoms.

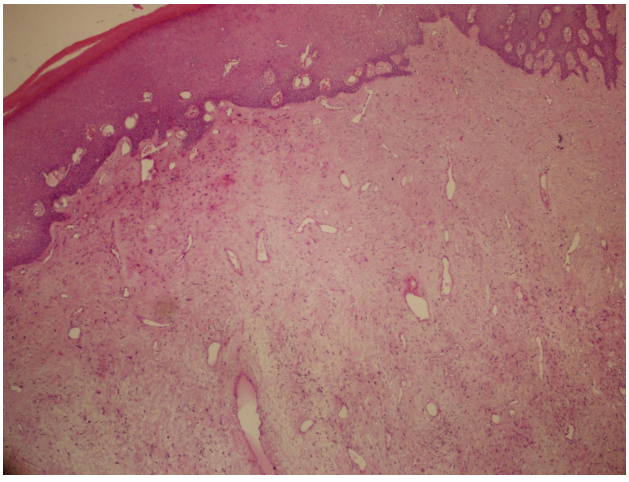

**Figure 2.** Histological features of the fibroepithelial polyp. Histologic sections of skin show a polypoid lesion with overlying mildly acanthotic epidermis. There is an edematous fibrovascular core with mild chronic inflammation (HE x 40).

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