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Filiform polyposis of ulcerative colitis

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A 39-year-old man admitted with bloody diarrhea. He had had a 16-year history of
ulcerative colitis (UC). He had not visited the clinic regularly and colonoscopy at the age of
36 disclosed filiform polyposis of the entire colon (FIGURE 1A). On admission, abdominal

CT scan disclosed marked wall thickening of the colon (FIGURE 1B). Six days later, he had acute onset of severe abdominal pain. Peritoneal signs were noted and CT scan disclosed free air, suggesting the bowel perforation. Thus he underwent emergent colectomy and ileostomy. Post-operative course was uneventful. The entire surface of resected colon was covered with numerous filiform polyps (FIGURE 1C, 1D, and 1E) and the perforation site was identified in the ascending colon (FIGURE 1F). The presence of the fibrovascular core (FIGURE 1G) confirmed the pathological diagnosis of filiform polyposis.

Post-inflammatory polyps (PIPs), also known as “pseudopolyps”, are non-neoplastic lesions originating from the mucosa after repeated periods of inflammation and ulceration associated with excessive healing processes [1]. They are usually associated with inflammatory bowel diseases (UC, Crohn’s disease), intestinal tuberculosis, and diverticular disease. PIPs vary in size with different patterns of distribution and morphology and are classified into localized multiple polyposis, giant polyposis, generalized polyposis, and filiform polyposis [2]. Filiform polyposis is characterized by numerous finger-like inflammatory polyps. These polyps form from the residual mucosal areas surrounded by ulcers and the fecal stream may elongate these tags to create slender forms [2, 3]. PIPs have been associated with a 2-fold increased risk of colorectal cancer, but they do not seem to have malignant potential in themselves. It is possible that PIPs may obscure the adequate visualization of neoplastic lesions in endoscopic surveillance or that their presence is just an evidence of previous severe inflammation leading to cancer [1, 4, 5]. Surveillance chromoendoscopy with targeted biopsies in appropriate interval is the key to detect neoplastic lesions earlier and determine the indications for colectomy [1, 5]. Surgery is required in cases of cancer, bowel obstruction, or perforation, as in this case. There is a general acceptance that if PIPs without any complications are adequately surveyed during endoscopy, no removal is considered mandatory [1].

Figure legend

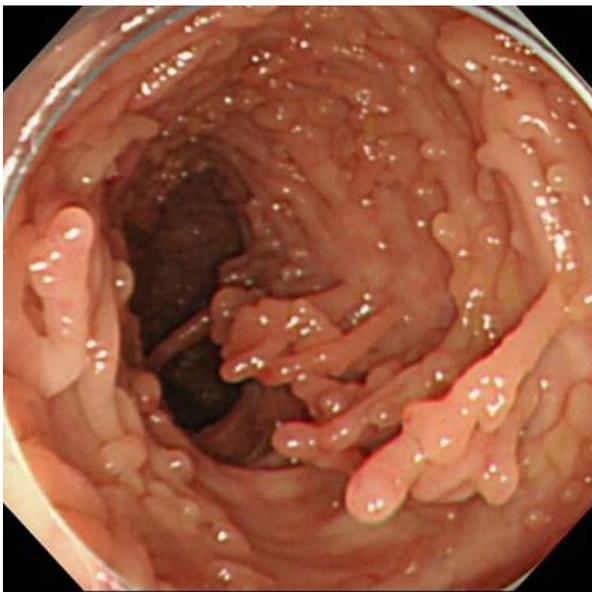


Figure 1A. Colonoscopic findings of multiple filiform polyps in the descending colon.



Figure 1B. Abdominal CT scan demonstrating marked dilatation of the ascending and transverse colon.



Figure 1C. Macroscopic findings of the pre-fixed resected colon. Numerous filiform polyps are shown in the entire colon.



Figure 1D. The length of a typical filiform polyp is approximately 25 mm.



Figure 1E. Macroscopic findings of the formalin-fixed resected colon.

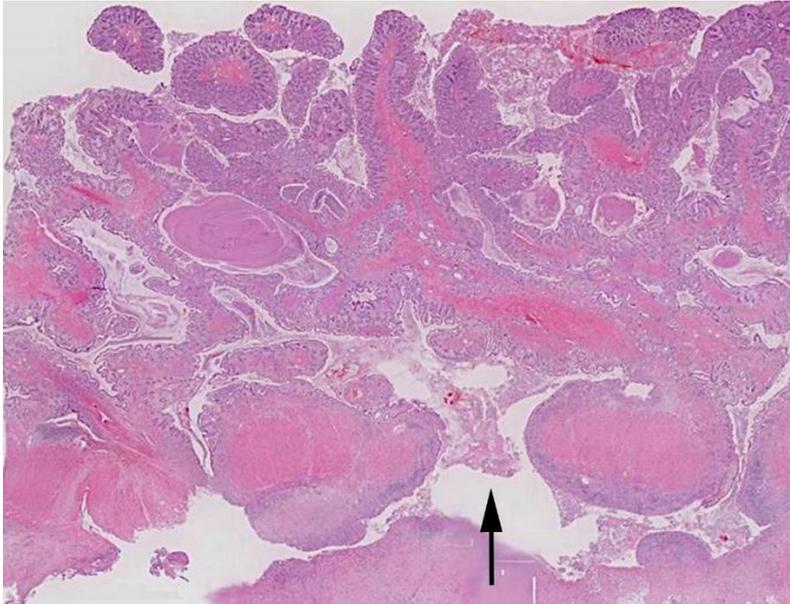


Figure 1F. Pathological findings of the numerous filiform polyps, deep fissure-like ulceration, and the perforation of the colonic wall (arrow) in the ascending colon.

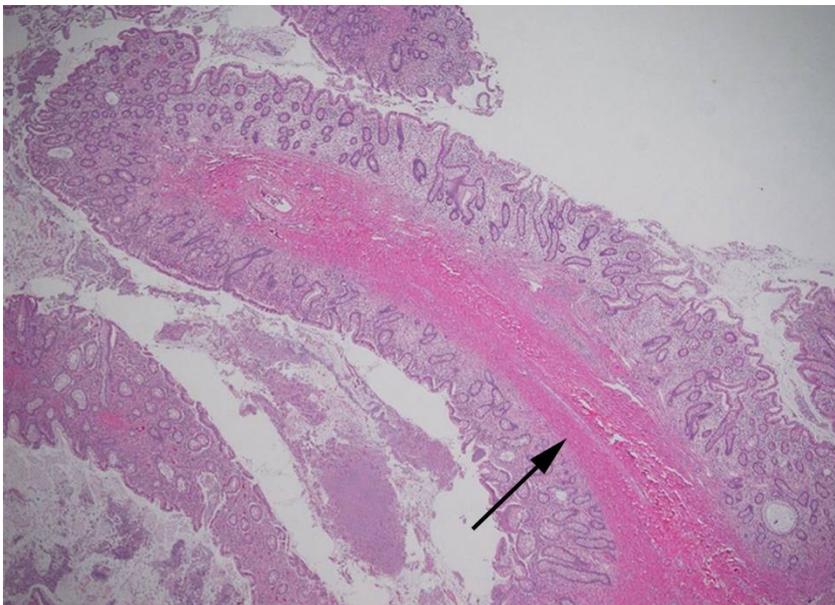


Figure 1G. Note the fibrovascular core (arrow), which is the characteristic feature of the filiform polyp.

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