Unusual polyposis in ulcerative colitis

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A 32-year-old male presented in April 2012 with intermittent pain in the abdomen for 2 years. Frequency of abdominal pain increased over a period of 6 months and was associated with loose stools mixed with blood and mucus. He had lost 6 kg in weight over a period of 6 weeks. There was no history of jaundice, Koch's bacillus, diabetes or hypertension. Physical examination was unremarkable except for pallor. Routine investigation showed hemoglobin 10g/dL, total WBC count 17,030/cmm, platelet 560,000/cmm. Serum alanine aminotransferase (ALT) was 21 IU/L, serum creatinine was 0.8 IU/L, and serum electrolytes were within normal limits. Colonoscopy revealed ulceration, loss of vascularity and friability of mucosa involving the rectum and the entire colon up to cecum (pancolitis) suggestive of ulcerative colitis. Rectal biopsy showed basal plasmacytosis, crypt distortion with cryptitis and loss of goblet cells which was consistent with ulcerative colitis. The patient was treated with oral prednisolon 40 mg at baseline with a tapering dosage and 5 aminosalicylate tablets (5 ASA) 800mg t.i.d. At the end of 2 weeks of treatment the symptoms improved. Steroids were stopped and 5 ASA was continued.

In October 2012 the patient complained of generalized weakness. Bowel frequency was twice daily. There was no history of blood in stool. Colonoscopy done at this time showed extensive colonic polyposis mainly involving the rectosigmoid area. Polyps were pedunculated and sessile ranging from 2 mm to 2 cm. The surface of the polyps on endoscopy was covered with fibrous exudates suggestive of cap polyposis (Fig. 1A). Intervening mucosa appeared to be in remission. Three larger polyps were resected endoscopically and submitted to histopathological examination. On microscopic examination, there was polypoidal configuration of rectal mucosa, covered with a cap of granulation tissue, suggestive of cap polyposis (Fig. 1B). Adjacent rectal mucosa showed elongated and branched crypts. Lamina propria inflammation was mild. There was no evidence of adenomatous change or malignancy.

Cap polyps are rare types of polyps with distinct endoscopic and histological features [1-4]. This lesion was first described by Williams GT [5] in 1985. To our knowledge, no more than 100 cases have been reported in the literature [1-6]. Cap polyps are identified by the presence of a fibrinopurulent cap on endoscopy and on histology they are characterized by dilated and elongated crypts with a cap of granulation tissue on the surface. Exact etiology is not known. Various possible causes include mucosal prolapse syndrome, ischemia, abnormal bowel motility or inflammation [7-9]. Diarrhea with blood and mucus is the most common presentation of cap polyposis. Clinically they can be misdiagnosed as ulcerative colitis leading to inappropriate treatment [6]. Histopathology can differentiate cap polyposis from inflammatory pseudopolyps of ulcerative colitis by presence of cap of granulation tissue. This was a case of cap polyposis developed in patient of ulcerative cilitis, six months later. Patient did not respond to therapy and was subjected to total colectomy. Awareness of this condition and additional case studies are required to evaluate clinical couse of cap polyposis.

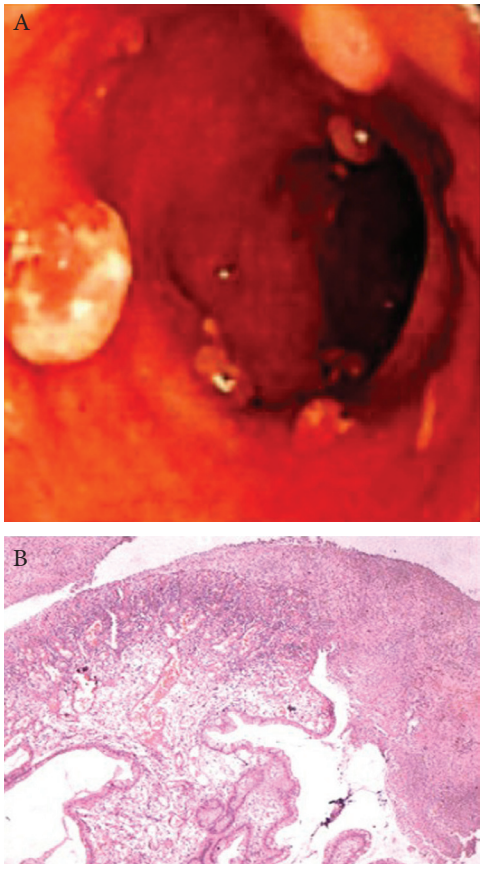

Figure 1 (A) Multiple polyps at endoscopy with fibrinopurulent cap. (B) Polypoidal configuration of colonic mucosa with a cap of granulation tissue on the surface suggestive of cap polyposis (HE 100X)

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