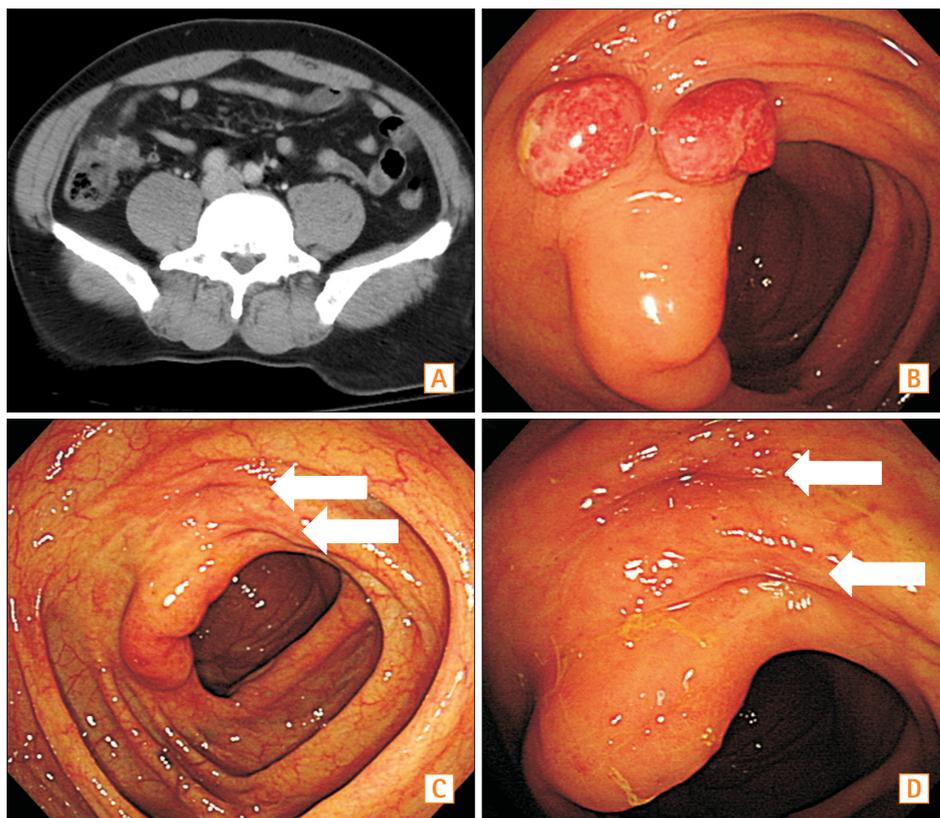




## Two hyperemic polypoid lesions in the colon

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**Question:** A 49-year-old man visited an endoscopic center for screening colonoscopy. The patient had experienced an episode of diverticulitis 5 weeks before the colonoscopy. At admission for that episode, he reported a 2-day history

of lower abdominal pain. His blood pressure was 118/74 mmHg; pulse rate, 97/min; respiration rate, 20/min; body temperature, 38.8°C. His laboratory data were white blood cell count, 11,800/ $\mu$ L (neutrophil count, 9,995/ $\mu$ L); hemoglobin level, 14.7 g/dL; and CRP level, 3.09 mg/dL. Abdominal CT showed focal wall thickening with infiltration around the terminal ileum to the cecum (Fig. A). He was diagnosed with diverticulitis and treated with antibiotics. He was discharged without complications. At follow-up at the outpatient department a week after discharge, he had no residual symptoms except mild right lower quadrant tenderness. He had never

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had a colonoscopy before; a screening colonoscopy was recommended.

The colonoscopy was performed 5 weeks after discharge for diverticulitis. Colonoscopy revealed six polypoid lesions in his colorectum. Among these, two lesions on the medial (mesenteric) side of the proximal ascending colon near the ileocecal valve were about 1 cm in diameter and of the Isp type with hyperemic surfaces (Fig. B). They had a hard consistency and showed easy touch bleeding. The surrounding mucosa was normal. They did not recede with air insufflation or upon palpation with forceps. Specimens were taken from the lesions (Fig. B) by forceps biopsy. On histologic examination, chronic inflammation and inflamed granulation tissue were found in the lesions on the ascending colon near the ileocecal valve. At a follow-up colonoscopy 4 months later, the lesions had disappeared and two openings of diverticulum were noticed in the same location near the ileocecal valve (Fig. C and D, white arrows).

What is the diagnosis of these lesions (Fig. B)?

#### **Answer to the Images: Inflammatory Polyps/Pseudopolyps Caused by Diverticulitis**

In the context of the follow-up colonoscopy findings and his history of diverticulitis, we diagnosed “inflammatory polyp/pseudopolyp caused by diverticulitis.” The terms inflammatory polyp and pseudopolyp have the same meaning and have been used interchangeably. Inflammatory polyps often develop during chronic inflammation in patients with inflammatory bowel disease and have been associated with other types of colitis.<sup>1-3</sup> There are several reports about inflammatory polyps, and there are some reports about inflammatory polyps associated with diverticulosis.<sup>3</sup> However, there is no prior report of an inflammatory polyp caused by diverticulitis. Diverticulitis results in hyperemic and edematous mucosa around the diverticulum, it generally does not induce polypoid lesions. The polypoid lesions-inducible factors are uncertain.

There are some reports about pseudopolyps related to inverted diverticulum. Most reported inverted diverticulum

cases are not inflamed; they are just inverted and are the same color as the surrounding mucosa. Inverted diverticulum recedes with air insufflation or in response to forceps.<sup>4,5</sup> However, diverticulitis does not develop in inverted diverticulum.

The facts that are undeniable in this case are “diverticulitis 5 weeks prior,” “inflammatory polypoid lesion,” “diverticular opening appeared after spontaneous regression of the lesion,” and “all of these phenomenon developed at the same site.” Therefore, the patient was diagnosed with inflammatory polyp caused by diverticulitis. Mucosal edema caused by diverticulitis developed inside the colon.

During the first colonoscopy, only biopsies were taken considering both their appearance that was unlike an adenomatous polyp and the patient’s history of diverticulitis. After colonoscopy, I discussed the issue with the patient and planned a follow up colonoscopy. Because of the risk of perforation when resecting an inverted diverticulum and the possibility of lesions’ spontaneous regression, the patient was treated conservatively. In hindsight, it was revealed that the management decision was correct.

As far as I know, this is the first reported case of an inflammatory polyp caused by diverticulitis. Endoscopists should be aware of the possibility of an inflammatory polyp after diverticulitis.

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