A small, yellowish nodule in the rectum: not as benign as it seems

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Short title: Small yellowish nodule in the rectum

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A 74-year-old woman was referred to the endoscopy unit for colonoscopy because of a change in bowel habits. The examination revealed a wide base polypoid lesion in the rectum, 10 mm in size with typical appearance of neuroendocrine tumor (NET) – yellowish, with smooth, intact covering mucosa (Figure 1A). Against guidelines, a hot snare polypectomy was used to remove the lesion. Histopathological examination showed a well differentiated (G1) NET with a positive vertical margin. The patient did not make an appointment for follow-up visits. After 53 months, she was referred to the department of gastroenterology with right hypochondrial pain, weight loss and recurrent episodes of fresh blood in a stool. The physical examination revealed abdominal distension with enormous liver enlargement (Figure 1B). The abdominal ultrasound (Figure 1C) and computed tomography (CT) scan showed numerous metastatic lesions in the liver, bones, and adrenal glands. The bulging, bleeding tumor of the rectum, invading muscularis propria was demonstrated during endosonography (Figure 1D). The biopsy confirmed the neuroendocrine origin of the tumor. Despite treatment by chemotherapy, the patient died after 6 months.

The rectal NETs originate from the muscularis mucosa and grow towards the submucosa[1]. Therefore, the polypectomy with diathermic loop or forceps biopsy, routinely performed during colonoscopy in the case of epithelial polyps, here, rarely leads to radical treatment[1]. Most rectal NETs have a characteristic morphological image: they are nodules on a wide base, a smooth surface, yellow color with a central hollow or hyperemia[1]. These features allow to make a proper diagnosis during colonoscopic examination and apply recommended method of treatment according to tumor size, grade and stage: endoscopic submucosal dissection (ESD), endoscopic mucosal resection (EMR), transanal endoscopic microsurgery (TEM) or surgical treatment[1]. When radical treatment is applied, the prognosis for rectal G1 NETs with the diameter up to 10 mm is very good, with nearly 100% 5-year survival rate, and these tumors do not even require follow-up[1]. Unfortunately, in spite of clear recommendations, what is apparent through our patient's story and other studies, is that majority of these lesions are resected with a snare polypectomy[2, 3], what may lead to incomplete resection, and subsequently metastatic spread [2-5]. Moreover, the...
important factor that led to the fatal outcome was the fact that the patient was lost for follow-up. There are no clear and evidence based guidelines showing optimal management in case of not radical resection of rectal NET; in such case either a close follow-up or a salvage therapy of the scar with ESD or TEM should be applied[4]. Therefore, taking into account the mistakes we see in our practice, we decided to present this case to underline the meaning of guidelines compliance and to show potential fatal consequences of ignoring the recommendations in rectal NETs.
Figure 1A. Endoscopic view of 10 mm rectal polyp with a typical neuroendocrine tumor appearance.
Figure 1B. Abdominal distension caused by liver enlargement (the line shows the liver borders).
Figure 1C. Metastatic tumor in the liver seen in abdominal ultrasound.
Figure 1D Endoscopic view of rectal neuroendocrine tumor recurrence after non-radical resection.
Figure 1E. Endoscopic ultrasound shows the hypoechoic rectal tumor invading muscularis propria.

References


