

Filiform polyposis in ulcerative colitis

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A 39-year-old man with a 16-year history of ulcerative colitis presented with bloody diarrhea. He had not visited the clinic regularly, and colonoscopy at the age of 36 showed filiform polyposis of the entire colon (**FIGURE 1A**). On admission, an abdominal computed tomography (CT) scan showed a 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 revealed free air, suggesting bowel perforation. Thus, the patient underwent emergent colectomy and ileostomy. The postoperative course was uneventful. The entire surface of the resected colon was covered with numerous filiform polyps (**FIGURE 1C–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.

Postinflammatory polyps (PIPs), also known as “pseudopolyps,” are nonneoplastic lesions originating from the mucosa after repeated periods of inflammation and ulceration connected with excessive healing processes.¹ They are usually associated with inflammatory bowel diseases (ulcerative colitis, Crohn disease), intestinal tuberculosis, and diverticular disease. PIPs vary in size, with different patterns of distribution and morphology, and are classified into localized multiple, giant, generalized, 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

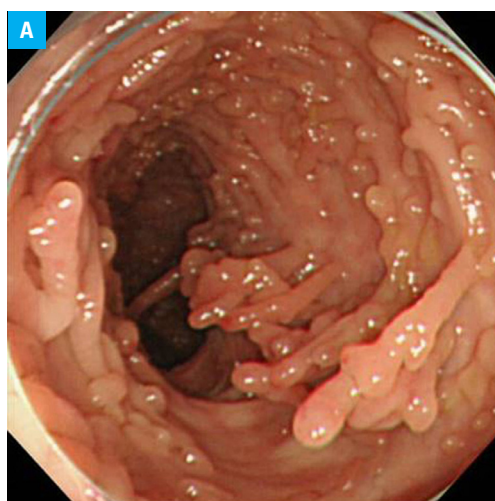


FIGURE 1 **A** – colonoscopic findings of multiple filiform polyps in the descending colon; **B** – abdominal computed tomography scan demonstrating marked dilation of the ascending and transverse colon; **C** – macroscopic findings of the prefixed resected colon; numerous filiform polyps shown in the entire colon

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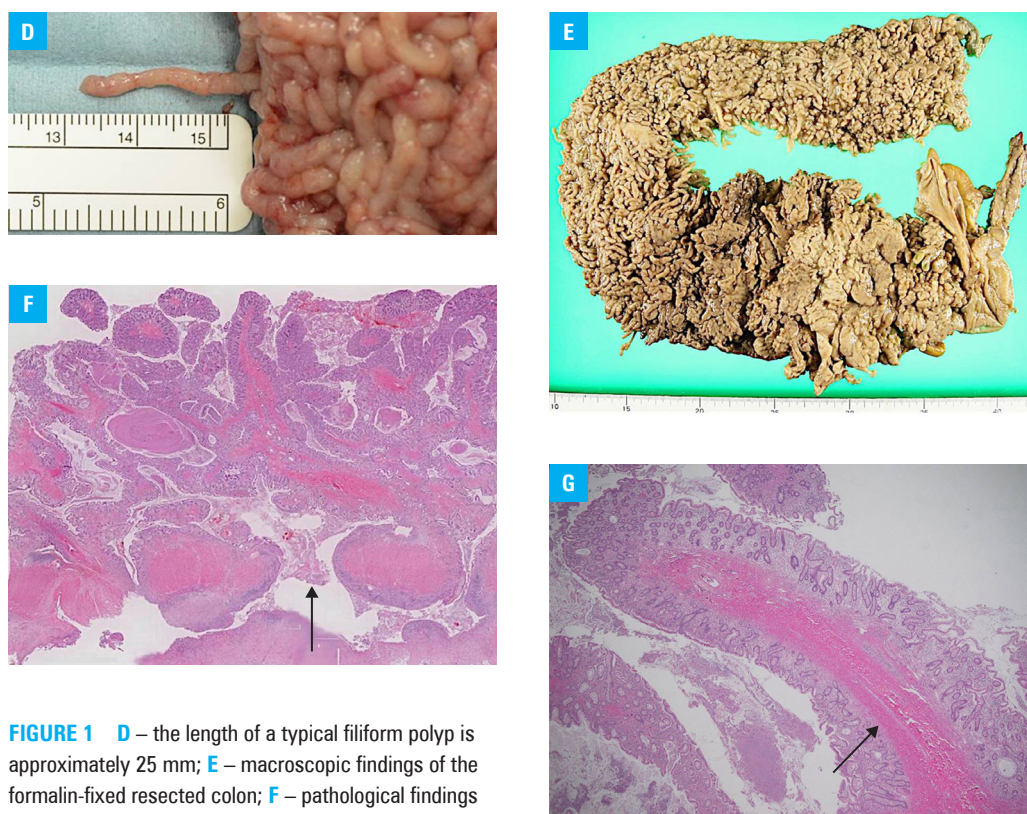


FIGURE 1 **D** – the length of a typical filiform polyp is approximately 25 mm; **E** – macroscopic findings of the formalin-fixed resected colon; **F** – pathological findings of the numerous filiform polyps, deep fissure-like ulceration, and the perforation of the colonic wall (arrow) in the ascending colon; **G** – note the fibrovascular core (arrow), which is the characteristic feature of the filiform polyp.

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 at appropriate intervals 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

ARTICLE INFORMATION

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CONFLICT OF INTEREST None declared.

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