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Anastomotic Colonic Inflammatory Polyp as a Cause of Large Bowel Obstruction: A Case Report

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Abstract
We report the case of a 55-year-old male who complained of colicky abdominal pain, progressive abdominal distension,constipation and bilious vomiting, eight days after a left hemicolectomy and colo-colic anastomosis. The previous operation was for a colo-colic intussusception where a submucous lipoma was found as the lead point.
Physical examination revealed a middle aged man in obvious respiratory distress, tachycardia,grossly distended abdomen and absent bowel sound .A clinical diagnosis of intestinal obstruction was made, resuscitation with intravenous fluid was commenced, nasogastric tube was passed for decompression and a Foley's catheter was passed. Plain abdominal radiograph showed distended bowel loops mainly in the periphery and lack of bowel gas in the rectum. He underwent an emergent laparotomy.The anastomotic site was completely obstructed, it was resected, and an end colostomy was sited.
Histopathology revealed inflammatory polyp.Colostomy reversal was performed a few months later .

Key words: inflammatory polyp, large bowel obstruction, anastomosis

Introduction

Colonic inflammatory polyp is a rare benign intraluminal projection of the colonic mucosa. It consists of a mixture of stromal and epithelial components as well as inflammatory cells.[1]

Predisposing conditions include ulcerative colitis and Crohn's disease, occurring in up to 20% of patients with ulcerative colitis.[2]

It may arise anywhere in the colon following an intense inflammatory process or at an anastomotic site.

It may be an incidental finding at colonoscopy, a lead point for intussusception or a cause large bowel obstruction.[1]

We present a 55 year old man who developed large bowel obstruction following a left hemicolectomy and colo-colic anastomosis for a left colo-colic intussusception.

Case presentation

Our patient is a 55year old man who presented with colicky abdominal pain, progressive abdominal distension, constipation and bilious vomiting, eight (8) days after a left hemicolectomy and colo- colic anastomosis.

Physical examination revealed a middle aged man in obvious respiratory distress, tachycardia,grossly distended abdomen and absent bowel sound .

Per rectal examination revealed an empty rectum.

A clinical diagnosis of intestinal obstruction was made, resuscitation with intravenous fluid was commenced, nasogastric tube was passed for decompression as well as urethral catheterization.

His plain abdominal radiograph is as depicted in fig 1.

He had an emergent laparotomy, the intra-operative findings were distended small and large bowel loops proximal to the anastomotic site, with collapse of distal segment.

Milking distally was attempted but unsuccessful because of complete obstruction at the anastomotic site.

The anastomotic site was resected, and an end colostomy was sited.

Histopathology revealed an inflammatory polyp as the cause of large bowel obstruction

He underwent colostomy reversal about 3 months later

His recovery was uneventful.

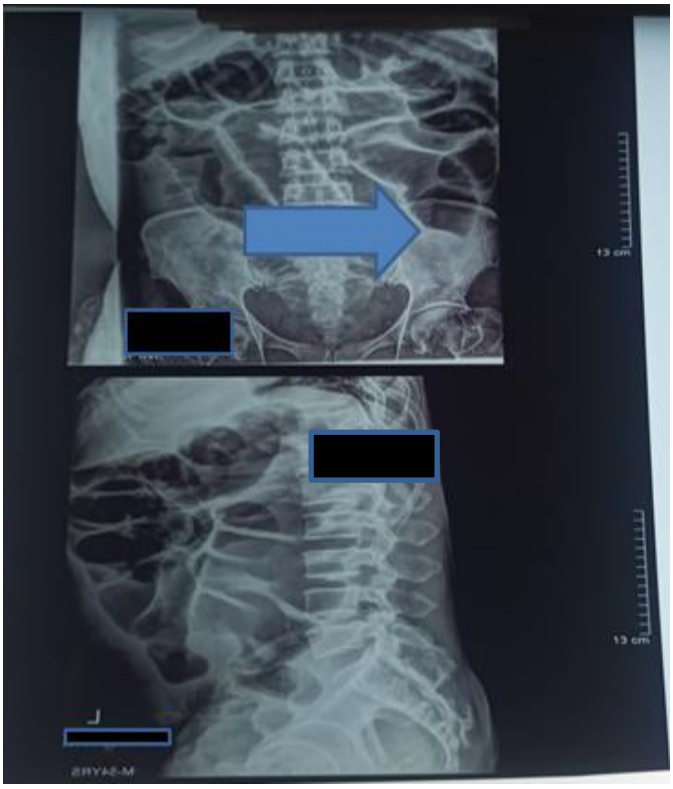

Fig 1: plain abdominal radiograph of the patient showing distended bowel loops and abrupt cut off of bowel gas

Discussion

Inflammatory polyps may occur in patients with inflammatory bowel disease [2], it occurs more commonly in patients with ulcerative colitis than in colonic Crohn's disease[4,5]. Our patient did not have any symptoms suggestive of inflammatory bowel disease.

It also occurs in ischemic colitis[6], infectious colitis[7], mucosal inflammation, ulceration and tissue regeneration. Healing processes at the anastomotic site probably predisposed our patient to the development of the polyp.

It has been established that overall, it is more common in patients with inflammatory bowel diseases than any other forms of colitis[8].

It is termed giant inflammatory polyp (GIP) when greater than 1.5cm[9].

Colonic inflammatory polyp may be asymptomatic, it may present with lower gastrointestinal bleeding or large bowel obstruction[10].However our index patient was symptomatic, he presented with obstructive symptoms large.

Diagnosis may be suggested by characteristic colonoscopic findings: hyperemia and surface ulceration, irregular and elongated contour with engorged surface, appearance of a mucosal appendage, and white cap at the polyp tip[11].

Preoperative colonoscopy was not done in this patient, as he was acutely ill with distended abdomen .

The definitive cause was known after histopathologic examination of the resected stenosed previous anastomotic site.

Treatment options are endoscopic and surgical.Endoscopic procedures that have been reportedly used include argon plasma coagulation[12], endoscopic loop polypectomy [13], YAG laser[14] and endoscopic resection with electrocautery[15].

Surgical options are typically deployed following failure of endoscopy methods or in complicated cases such as bowel obstruction [16]. Surgical options include segmental resection, right and left hemicolectomy[17.] The choice of the surgical procedure depends on the location of the polyp.Our patient underwent laparotomy and segmental colonic resection with colostomy.Colostomy reversal was performed about three months later and he recovered fully.

Conclusion

Anastomotic colonic inflammatory polyp, though rare, should be considered in the differential diagnosis of post operative large bowel obstruction.Prompt diagnosis, resuscitation and appropriate treatment should be instituted in order to achieve a favourable outcome.

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