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# Recurrent Giant Pseudopolyp: Case Report and Review of the Literature

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## Rezumat

***Pseudopolip gigant recurent: prezentare de caz și review de literatură***

*Introducere:* prezentăm cazul unui pacient fără antecedente de boală inflamatorie intestinală (BII), diagnosticat cu un pseudopolip gigant recurent, asimptomatic timp de nouă ani.
*Prezentarea cazului:* un bărbat caucazian în vârstă de 51 de ani, fără antecedente medicale relevante, a fost spitalizat pentru o formațiune tumorală subocluzivă localizată în colonul drept, suspectată a fi de natură neoplazică. S-a decis practicarea unei hemicolectomii drepte, iar examenul histopatologic a relevat prezența unui pseudopolip gigant, fără semne de malignitate. S-a recomandat monitorizarea pentru BII, însă aceasta nu a fost realizată. După nouă ani, pacientul s-a prezentat cu un tablou clinic similar, iar o altă formațiune a fost descoperită la nivelul anastomozei anterioare. Excizia chirurgicală a confirmat prezența unui alt pseudopolip gigant, fără dovezi de neoplazie.
*Concluzie:* pseudopolipii giganți, deşi adesea asociați cu BII, pot apărea şi la pacienți fără un istoric inflamator anterior. Acest caz subliniază necesitatea includerii pseudopolipilor în diagnosticul diferențial al maselor colice, chiar şi în absența BII, pentru a evita morbiditatea chirurgicală inutilă.

**Cuvinte cheie:** pseudopolip gigant, boală intestinală ne-inflamatoare, mase colonice

## Abstract

*Introduction:* we report the case of a recurrent giant pseudopolyp occurring in a patient without a history of inflammatory bowel

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disease (IBD), with an asymptomatic interval of nine years.
*Case Presentation:* a 51-year-old Caucasian male with no relevant medical history was hospitalized for a subocclusive mass in the right colon, suspected to be neoplastic. He underwent a right hemicolectomy, and histopathology revealed a giant pseudopolyp without malignancy. Follow-up for IBD was recommended but not completed. Nine years later, the patient presented with a similar clinical picture, and another mass was found at the site of the prior anastomosis. Surgical excision confirmed another giant pseudopolyp with no evidence of neoplasia.
*Conclusion:* giant pseudopolyps, while often associated with IBD, can occur in patients without a prior inflammatory history. This case underscores the need to include pseudopolyps in the differential diagnosis of colonic masses, even in the absence of IBD, to avoid unnecessary surgical morbidity.

**Key words:** giant pseudopolyp, non-inflammatory bowel disease, colonic masses

## Introduction

Giant pseudopolyps are rare post-inflammatory polyps, generally found in patients with a history of IBD, such as Crohn's disease or ulcerative colitis (1,2). These lesions, often exceeding 1.5 cm (1-4), can mimic malignancy due to their size and clinical presentation5,6. Although commonly linked to IBD, cases of giant pseudopolyps in patients without IBD have been reported, though they remain rare.

This report presents a unique case of recurrent giant pseudopolyps in a patient without documented inflammatory disease, presenting as obstructive colonic masses nine years apart. The case highlights diagnostic challenges, mechanisms of recurrence, and the importance of distinguishing pseudopolyps from other lesions such as villous adenomas and juvenile polyps.

## Case Report

A 51-year-old caucasian male with a history of hiatal hernia, hepatitis B, and regular tobacco and alcohol use presented to the emergency department with one month of abdominal pain, altered bowel habits, hematochezia, and weight loss. Examination revealed a right hypochondrial mass. Radiological examination (CT-scan) revealed a 10 cm mass at the hepatic flexure of the right colon, associated with lymphadenopathy (*Fig. 1*). Colonoscopy confirmed an obstructive lesion at 100 cm of anal margin, without passing possibility. The mass was biopsied, showing an inflamed colonic mucosa. CEA levels were normal (2.5 ng/mL).

According to malignancy suspicion, surgical indication of right hemicolectomy was retained after oncological multidisciplinary concertation. This was performed under coelioscopy, post-operative course was uncomplicated.

Pathological examination revealed an 8 cm giant pseudopolyp without dysplasia or malignancy, perforating to the subserosa, and accompanied by significant inflammation. Forty-two lymph nodes were benign. Follow-up for underlying IBD was recommended but not completed.

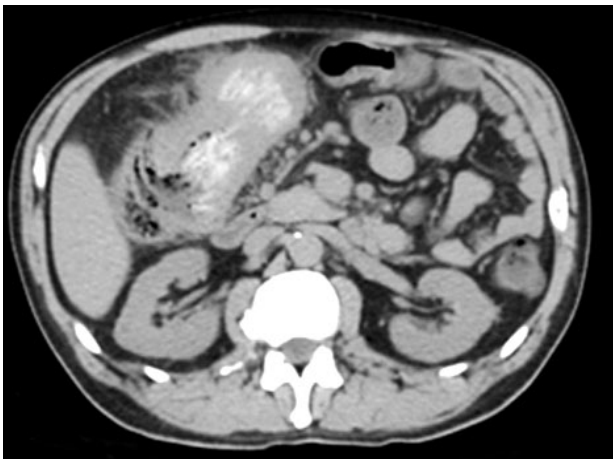

**Figure 1.** CT scan showing a 10cm tumor of the right colon, located at the hepatic angle.

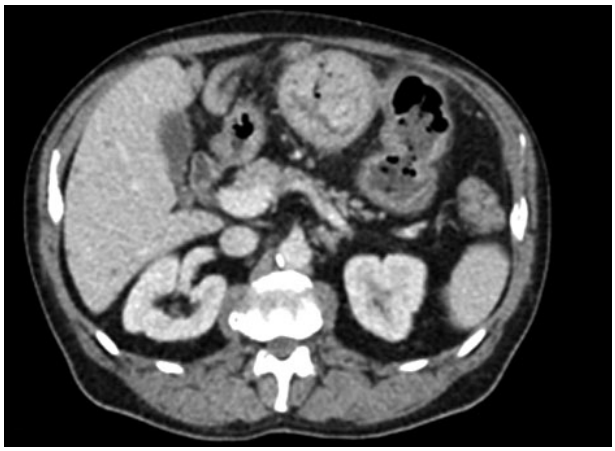

**Figure 2.** CT-scan showing a 9 cm subocclusive tumor located at the previous anastomosis.

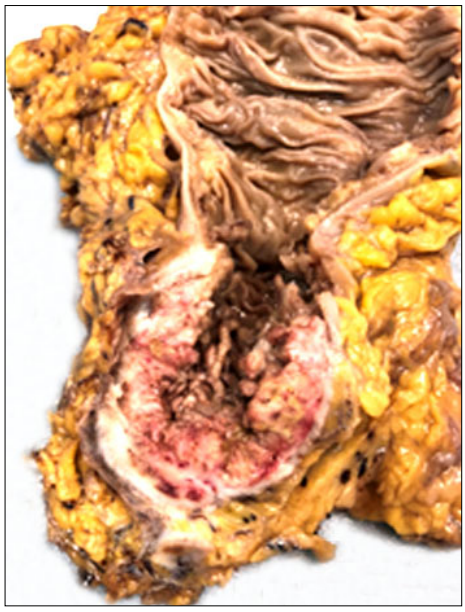

**Figure 3.** Ileocolic resection piece showing the obstructing mass (macroscopically)

Nine years later, the patient returned with similar symptoms. A CT scan identified a 9 cm subocclusive lesion at the previous anastomotic site (*Fig. 2*). Tumor markers were negative. A second surgical resection revealed a 6 cm pseudopolyp with villous morphology and inflammation but no dysplasia or malignancy. This anastomotic site was surgically resected, pathological examination revealed finger-like projections with ulceration, fibrosis, and inflammatory infiltrate (*Fig. 3* and *4*). No immunohistochemistry was performed.

## Discussion

The diagnosis of pseudopolyp hinges on histopathological findings (7,8). Inflammatory pseudopolyps show active inflammation with crypt hyperplasia and architectural disorganization. Post-inflammatory pseudopolyps, in contrast, arise during remission and exhibit fibrosis with minimal inflammation. While immunohistochemistry is not essential for making the histological diagnosis, it can be helpful in the differential diagnosis, assisting in the exclusion of other conditions, such as histiocytosis X or villous adenoma.

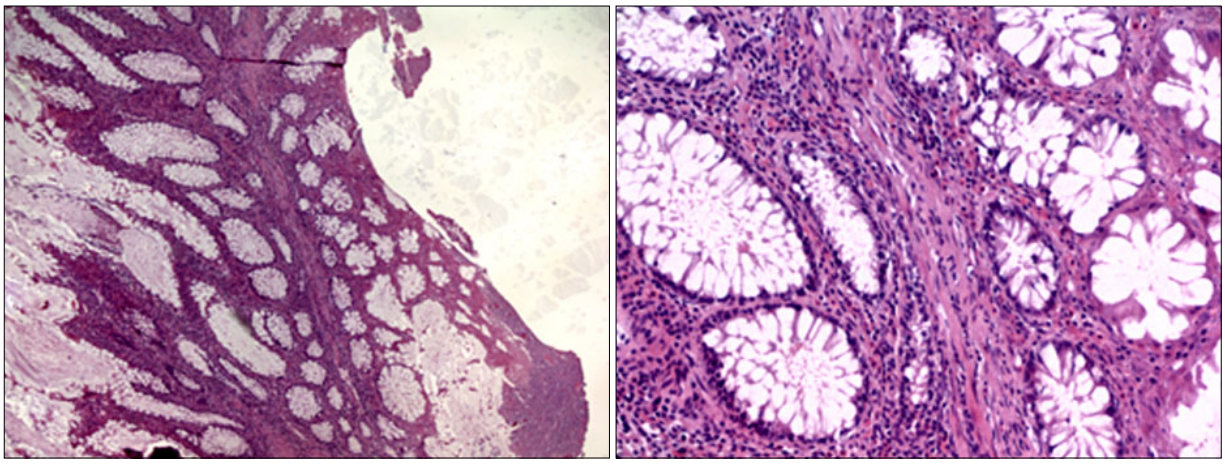

**Figure 4.** Microscopical: inflammatory changes of the colic wall, no signs of dysplasia

Differential diagnosis for pseudopolyp includes villous adenoma, juvenile polyps, and post-surgical reactive polyps. Unlike pseudopolyps, villous adenomas show dysplasia and have a malignant potential (9). Juvenile polyps typically arise in younger patients and lack the extensive inflammatory and fibrotic changes seen in pseudopolyps (10). Post-surgical reactive polyps may form at anastomotic sites and are histologically distinct from pseudopolyps.

The recurrence in this case may be attributed to persistent localized inflammation at the anastomosis, even in the absence of systemic IBD. Cyclical tissue injury and regeneration at this site likely perpetuated pseudopolyp formation, highlighting the importance of vigilant follow-up.

This case underscores the importance of considering pseudopolyps in the differential diagnosis of colonic masses, even without IBD. Radiological and endoscopic assessments may help avoid unnecessary colectomy. Endoscopic resection, when feasible, minimizes morbidity while ensuring histological confirmation (11,12).

The prolonged asymptomatic interval and absence of systemic inflammatory disease make this case unique. It emphasizes the need for long-term follow-up in patients with localized pseudopolyps, as recurrence may occur even without active inflammation.

European guidelines recommend surveillance colonoscopy every 2-3 years for patients with pseudopolyps (13), given their increased risk of colorectal cancer due to chronic inflammation (4,14,15).

## Conclusion

Giant pseudopolyps should be considered in the differential diagnosis of colonic masses, regardless of inflammatory history. Early diagnosis and conservative management, where feasible, can reduce surgical morbidity while ensuring effective treatment. Long-term follow-up is essential due to the potential for recurrence and associated cancer risks.

### *Author's Contributions*

Emanuele Calicis and Marion Culot contributed equally to this work.

### *Conflicts of Interests*

The authors declared no potential conflicts of interest.

### *Ethical Statement*

This publication did not involve any data requiring ethical approval.

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