

Vanishing cecal polypoid mass lesion

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CASE PRESENTATION

A 53-year-old man was referred because of colonoscopic identification by a surgeon of a large cecal polyp, possibly amenable to endoscopic removal. During the colonoscopic evaluation, no cecal lesion was seen by two expert gastroenterologists despite excellent visualization of the cecum. Ileal and appendiceal orifices appeared normal. After photographs were taken to document an apparently normal cecum (Figure 1), a large colonic polypoid mass appeared to partially, then subsequently fully prolapsed into the cecum during the procedure from the ileocecal orifice (Figure 2). This was later removed by laparoscopic resection and proved to be a villous adenoma of the cecum.

DISCUSSION

A few reports have documented intussusception of benign and malignant polypoid lesions in the ileocecal area of adults (1,2). Usually, patients experience intermittent abdominal pain and distension, sometimes with nausea and vomiting, suggesting an obstructing lesion. In adults, a well-defined pathological abnormality is often evident and the intussusception is believed to be caused by a specific pathological lesion associated with a freely moving segment telescoping into an adjacent fixed or retroperitoneal segment. As a result, a relatively common site of intussusception is the ileocecal area (3).



Figure 1) Normal cecum with no mass lesion

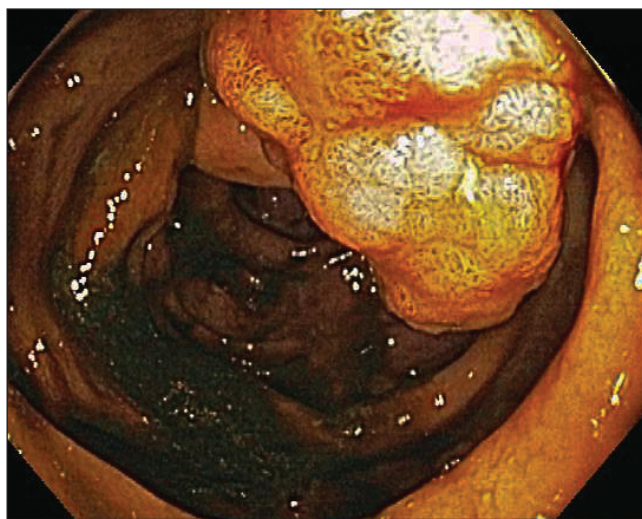


Figure 2) Fully prolapsed cecal mass lesion that proved to be a large villous adenoma

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Most often, preoperative diagnosis includes imaging studies, which have historically involved barium enema studies and, more recently, computed tomographic imaging. Occasionally, an intussusception may be confirmed by colonoscopic evaluation. In adults, operative treatment is usually required because the cause often proves to be carcinoma, lymphoma or carcinoid tumour. In the present case, definition of a large cecal lesion was not immediately apparent to two expert endoscopists, possibly because of initial air insufflation in the presence of a mobile ileocecal lesion. While apparently rare, endoscopists performing routine diagnostic or screening colonoscopy should be aware of the potential for missing even large neoplastic appendiceal (4) or ileal orifice lesions.

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