

DYSPLASTIC RECTAL POLYP (LOW GRADE)

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Villous adenoma is a non-cancerous growth in the colon. It develops from the cells that cover the inner surface of the large intestine. These adenomas can develop anywhere along the colon, from the cecum to the rectum. All villous adenomas are associated with an increased risk of developing colon cancer called adenocarcinoma over time. Polyps can be sessile or pedunculated and vary in size. The incidence of polyps ranges from 7–50%; a higher incidence refers to very small polyps (which are usually hyperplastic or adenomas) and are found as an incidental finding at autopsy.

A 72-year-old female patient K. D. presented because of bleeding during defecation and a change of the size of an apple that used to "fall out" from the anus during defecation. She reported to have experienced this change for more than a year and the bleeding from it in the last few weeks. She used suppositories, but there were no changes in the local findings. Further, she performed a colonoscopy, where a pale pink mucosa was seen, with normal findings, except for 3–4 cm, where there was a cauliflower-like change on the stalk, partially covered with fibrin deposits, hyperemic.

According to the data, the combined risk of dysplasia/malignancy is about 83% with a 50% risk of dysplasia and overt malignancy in 33% of cases of giant rectal villous adenomas larger than 8 cm. *Acta Medica Medianae* 2023;62(1):62-65.

Key words: tubulovillous adenoma, lifestyle, bleeding, cancer

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Introduction

By intestinal polyp we mean any tissue change that grows from the wall of the intestine and spreads into the lumen. Most polyps do not cause any symptoms except for mild bleeding which is usually hidden. Malignant transformation is the most worrisome; most cancers grow from previously benign adenomatous polyps. The diagnosis is made by endoscopy.

Polyps can be sessile or pedunculated and vary in size. The incidence of polyps ranges from 7% to 50%; a higher incidence refers to very small polyps (which are usually hyperplastic or adenomas) and are found as an incidental finding at autopsy. The rectum and sigmoid colon are the most common localization of polyps and they are often multiple. The frequency decreases towards

the cecum. Multiple polyps can occur as part of familial adenomatous polyposis. About 25% of colon cancer patients also have adenomatous polyps.

Adenomatous (neoplastic) polyps are histologically classified into tubular adenomas, tubulovillous adenomas (viloglandular polyps) or villous adenomas. The possibility of malignant transformation in an adenomatous polyp at the time of diagnosis depends on the size, histological type and degree of dysplasia; the risk of malignant transformation of a tubular adenoma with a diameter of 1.5 cm is 2%, compared to a 35% risk of a villous adenoma with a diameter of 3 cm.

Non-adenomatous (non-neoplastic) polyps include hyperplastic polyps, hamartomas, juvenile polyps, pseudopolyps, lipomas, and other rare tumors. **Peutz-Jeghers syndrome** is an autosomal dominant disorder with multiple hamartomatous polyps in the stomach, small intestine, and colon. Symptoms are dark pigmentation of the skin and mucous membranes, especially in the area of the lips and gums. Juvenile polyps occur in childhood. Treatment is only necessary in case of uncontrolled bleeding or intussusception. Inflamed polyps and pseudopolyps occur in chronic ulcerative colitis and Crohn's disease of the colon. Multiple juvenile polyps (but not sporadic) carry an increased risk

of cancer. The specific number of polyps for which there is an increased risk is not known.

Case report

A 72-year-old female patient K. D. presented because of bleeding during defecation and a change of the size of an apple that used to "fall out" from the anus during defecation. She reported to have experienced this change for more than a year and the bleeding from it in the last few weeks. She used suppositories, but there were no changes in the local findings. She performed a colonoscopy, where a pale pink mucosa was seen, with normal findings, except for 3–4 cm, where there was a cauliflower-like change on the stalk, partially covered with fibrin deposits, hyperemic.

In the objective findings, hemorrhoidal nodules were evident in the anal region, without signs of inflammation and bleeding. In addition to hemorrhoids, a raspberry-like change was observed that protrudes from the anus, light red in color, which was reposable back into the lumen.

biochemical analyzes (WBC: 8.29; RBC: 4.48; HGB: 104.8; HCT: 0.33; MCV: 74, 2; PLT: 335.6; albumin: 34; protein: 62.2; CRP: 2.7), X-ray of lungs and heart (normal findings), ECG (normal findings), the internist and anesthesiologist were consulted. After adequate preoperative preparation, the patient underwent operative treatment under conditions of local anesthesia and analgesedation. The patient was placed in the gynecological position.

Surgery (transanal excision) is prescribed if the formation has a villous, adenomatous structure and is removed from the anus up to 10 cm. After dilatation of the anus, a raspberry-like, adenomyomatous change was identified, which was attached to the anal canal on the stalk. The change was mobile.

After identification of the peduncle, pean is placed and the change is excised completely. At the excision site, a suture is made with a pair of stitches. Make a correct hemostasis.



Figure 1. Prolapsed adenoma



Figure 2. Identification of the adenoma stalk



Figure 3. Excision site suture



Figure 4. Extirpated adenoma in its entirety

The perianal region findings were normal.

In the surgery department where the patient was admitted, adequate preoperative preparation was done, which consisted of basic laboratory and

The preparation was sent for pathohistological verification. After two weeks, the pathologist's report was received with the diagnosis: *Adenoma tubulovilosum in malignant alteration*.

Discussion

Transanal minimally invasive surgery has emerged in recent years as a viable alternative to traditional radical resection for both benign and malignant rectal lesions (1). Severe colorectal polyps are lesions that present a challenge to traditional endoscopic polypectomy (2). Serrated polyps have been recognized in the last decade as important premalignant lesions that account for between 15% and 30% of colorectal carcinomas (3). Rectal lesions containing dysplasia or early neoplasia confined to the mucosa are usually treated by a minimally invasive transanal approach (4). Colorectal polyps are an important but uncommon cause of rectal bleeding (5). Polyps are often found throughout the large intestine, and a colonoscopy is therefore a useful method, especially in patients with occasional rectal bleeding. Indications for transanal polyp excision are: impossibility of endoscopic polyp excision, contraindications for general anesthesia due to existing comorbidities, polyp localization up to 10 cm from the anocutaneous line. Contraindications for transanal polyp excision are: multiple polyps, bleeding and the polyp localization more than 10 cm from the anocutaneous line. By statistical analysis, the malignant potential of adenomas is

related to their size, growth pattern and degree of epithelial atypia (6). Some high-risk patients receive insufficient monitoring, and lower-risk subjects receive excessive monitoring.

There are two main trends in the surgical treatment of precancerous conditions and early stages of rectal cancer: radical rectal resection and local transanal excision of the affected zone (7). Several lifestyle factors, primarily smoking and alcohol, are associated with the risk of colorectal polyps (8). We believe that the risk of colorectal polyps could be reduced by lifestyle changes. Most colon cancers develop from adenomas, and the life history of this sequence, although variable, probably lasts an average of 10 to 15 years (6). According to the data, the combined risk of dysplasia/malignancy is about 83% with a 50% risk of dysplasia and overt malignancy in 33% of cases of giant rectal villous adenomas larger than 8 cm (9).

Conclusion

Distinguishing adenoma from submucosal invasion remains a common challenge in clinical practice. The ideal treatment approach for any colorectal change should be one that is cost-effective, minimizes the need for follow-up interventions, and ultimately avoids surgery.

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Prikaz bolesnika

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doi: 10.5633/amm.2023.0109**DISPLASTIČNI REKTALNI POLIP NISKOGR STEPANA***Mladen Kasalović^{1,2}, Zlatan Elek^{1,2}, Gojko Igrutinović^{1,2}, Aleksandar Jakovljević^{1,2}, Nikola Miljković^{1,2}, Milica Milentijević^{1,2}*¹Kliničko-bolnički centar, Kosovska Mitrovica, Srbija²Univerzitet u Prištini sa privremenim sedištem u Kosovskoj Mitrovici, Medicinski fakultet, Kosovska Mitrovica, SrbijaKontakt: Mladen Kasalović,
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Vilozni adenom je nekancerozna izraslina u debelom crevu. Razvija se iz ćelija koje prekrivaju unutrašnju površinu debelog creva. Ovi adenomi mogu se razviti bilo gde duž debelog creva, od cekuma do rektuma. Svi vilozni adenomi povezani su sa povećanim rizikom od razvoja vrste raka debelog creva, tzv. adenokarcinoma tokom vremena. Polipi mogu biti sesilni ili na peteljci, te variraju veličinom. Incidencija polipa iznosi 7% – 50%; veća incidencija odnosi se na vrlo male polipe (koji su obično hiperplastični ili adenomi), te se nađu kao slučajan nalaz na obdukciji.

Pacijent K. D. starosti 72 godine, ženskog pola, dolazi zbog krvarenja pri defekaciji, kao i zbog promene koja „ispada“ iz anusa pri defekaciji, veličine jabuke. Za ovu promenu zna više od godinu dana. U poslednjih nekoliko nedelja promena krvari. Pacijentkinja je koristila čepiće, ali nije došlo do promena u lokalnom nalazu. Uradila je kolonoskopiju, gde je viđena sluznica bledoružičaste boje, urednog nalaza, osim na 3 cm – 4 cm, gde se uočava karfiolasta promena na peteljci, delom prekrivena fibrinskim naslagama, hiperemična.

Prema podacima, kombinovani rizik od displazije/maligniteta je oko 83%, sa 50% rizikom od displazije i otvorenog maligniteta u 33% slučajeva džinovskih rektalnih viloznih adenoma većih od 8 cm. *Acta Medica Medianae 2023;62(1): 62-65.*

Ključne reči: tubulovilozni adenom, način života, krvarenje, karcinom

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