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Inflammatory Cloacogenic Polyp: A Rare Type of Benin Polype

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Abstract **Case Report**

The inflammatory cloacogenic polyps are extremely rare benign lesions that affect the anal transition zone and the lower rectum where mucosal prolapse plays an important pathogenic role. They are mainly revealed by the rectal bleeding. Digestive endoscopy with biopsies allows diagnosis after histological confirmation. Endoscopic or surgical resection is the treatment of choice. We report a case revealed by rectal bleeding, with review of the literature.

Keywords: Cloacogenic polyp, prolapse, rectal bleeding.

INTRODUCTION

The cloacogenic polyps are extremely rare benign polypoid inflammatory lesions from the anorectal transition zone and may look macroscopically like malignant tumors [1], first described in 1981 as an unusual polyp of the anus, in which mucosal prolapse plays an important pathogenic role [2]. They can be associated with various pathologies (hemorrhoids, Crohn's disease, colonic diverticulosis or colorectal adenocarcinoma) [3].

We report a case of inflammatory cloacogenic polyp revealed by rectal bleeding, with review of the literature.

CASE REPORT

We report the case of a 53-year-old patient with post-HBV hepatic cirrhosis with no other medical condition history , particularly no neoplastic history, who consulted for chronic low-abundance rectal bleeding, that had been intermittently active for four years with diarrhea constipation alternation and sensation of "ball" at the anus without disorder of anal continence, in whom proctological assesment objectified the presence of painless externalized muco-hemorrhoidal rectal prolapse with several polypoid, sessile, inflammatory, red raspberry formations in intra-anal continuity to the lower part of the rectum, without internal hemorrhoids. (Fig-1) without other anorectal abnormalities and without sphincter disorders.

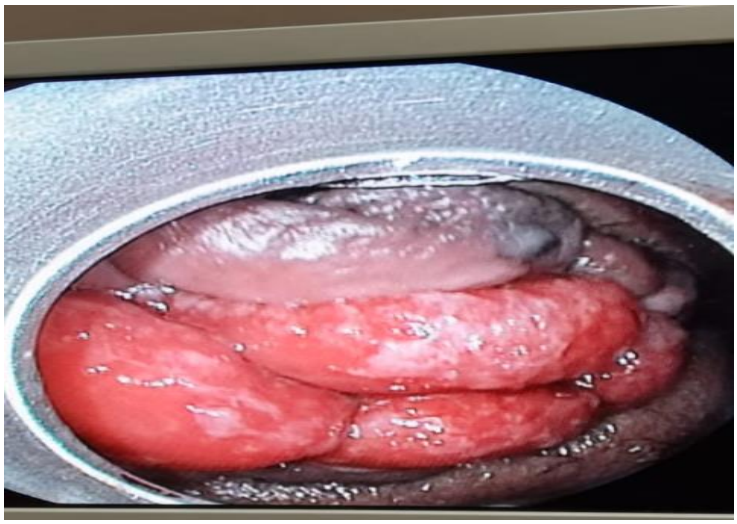

Fig-1: Image of muco- hemorrhoidal rectal prolapse of polypoid red raspberry appearance

The pathological study of polyp biopsy has found a colorectal mucosa arranged in tubes, the surface epithelial lining is cylindrical regular squamous, the chorion is fibrous seat of a mild inflammatory infiltration, diffuse and predominantly mononuclear, the crypts are irregular elongated branched. Aspect in favor of an inflammatory cloacogenic polyp without signs of malignancy (Fig-2).

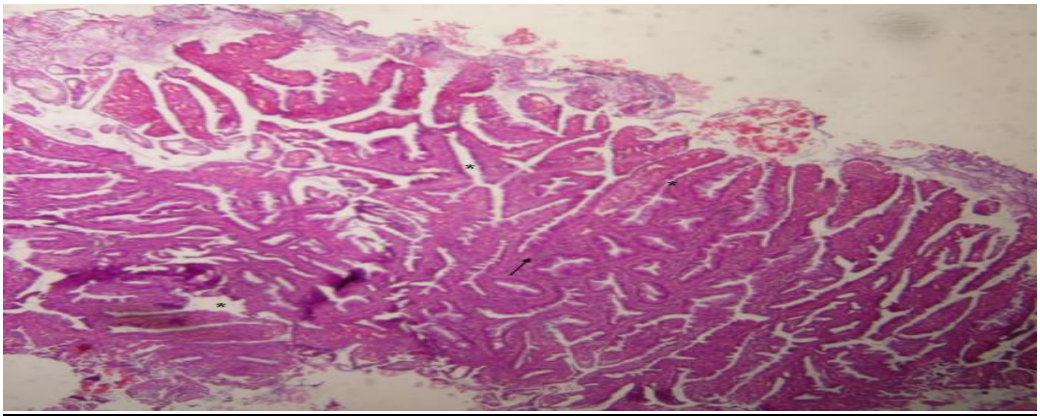

Fig-2: Cloacogenic Polyp: branched elongated crypts with chronic inflammatory changes

We completed the exploration by a complete colonoscopy which proved normal, however the biological assessment showed a hypochromic microcytic anemia at 4.3 g / dl with a thrombocytopenia at 35 000 / mm3 and a low prothrombin at 34%.

DISCUSSION

The inflammatory cloacogenic polyp is a non-neoplastic regenerative polypoid lesion of the anorectal transition zone, considered to be a subtype of solitary rectal ulcer or mucosal prolapse syndrome. It is a very rare lesion with an estimated annual incidence of approximately 1 to 3.6 per 100 000 of all solitary rectal ulcers. It has been described for the first time in the literature by Lobert and Appleman in 1981.

It is thought to result from mucosal prolapse due to dysfunction of the internal anal sphincter and smooth muscle of the rectum that produces local trauma and ischemic injury followed by inflammation, repair, and regenerative changes.

These polyps are more common in women during the third and fourth decade of life. Our patient is male, 53 years old. However, Poon *et al*., And Washington K reported cases in children and adolescents [5, 6].

Rectal bleeding, constipation and anal tenesmus are the most frequent telltale signs of these polyps. This is the case of our patient who initially consulted for rectal bleding of low abundance.

Polyps are often sessile rarely pediculate [7], solitary or multiple and generally located at the anterior wall of the anorectal junction, but Scott H has already reported in his series of cases that they may occur from the anterior wall, posterior or even anterolateral of the rectum.

Diagnosis is made through endoscopy with biopsy. Histologically, these are single or multiple lesions 0.5-5 cm (average 1 cm), tubulovillous architecture with varying proportions of squamous and cylindrical monostratified or cloacogenous coating, frequent mucosal erosions with granulation tissue underlying. A muscular hyperplasia, in the form of fibers associated with fibrous stroma rising in the chorion is possible. Hyperplastic crypts may extend to the submucosa or form pseudocysts [4].

The differential diagnosis is mainly with other types of inflammatory polyps, digestive neoplasia, inflammatory bowel disease and Cowden syndrome [8].

Endoscopic or surgical resection of these polyps associated with the correction of prolapse is the treatment of choice [9, 8], in our patient resection was not performed because of thrombocytopenia and low prothrombin. A high fiber diet is also recommended in these patients, as well as regular use of laxatives (polyethylene glycol) and the removal of intense and prolonged efforts to reduce the risk of mucosal prolapse [10].

Transformation into squamous cell carcinoma is mentioned. Dysplasia was detected in the cases of Parfitt *et al.*, [8] and Hanson and Armstrong found anal intraepithelial neoplasia in his case [9].

Endoscopic monitoring is recommended, although no dysplasia has been observed [10]. Gastroenterologists and pathologists need to be aware of this entity, which should be taken into account in the differential diagnosis with other anorectal lesions

CONCLUSION

Inflammatory cloacogenic polyps are rare lesions in the anal transition zone in which mucosal prolapse plays an important pathogenic role. The diagnosis is essentially endoscopic confirmed histologically after performing biopsies. This lesion again emphasizes the need for histological examination of all perianal lesions.

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