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Inflammatory cloacogenic polyp of the anal canal: an unusual cause of rectal bleeding

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CASE REPORT

ABSTRACT

Cloacogenic polyps are rare and benign inflammatory lesions located around the ano-rectal transition zone and can mimic neoplasia. We present the case of a 70-year-old man who consulted for rectorrhages and rectal syndrome, the proctological examination objectified a raspberry pedicle polyp 3 cm long delivered at the anal margin, a biopsy with pathological study confirmed the diagnosis of inflammatory cloacogenic polyp without dysplasia. Due to the potential for malignant transformation, the polyp was removed by endoscopy. Chronic inflammatory conditions such as crohn's disease and colorectal tumors are often associated. Total colonoscopy was performed without abnormalities.

Keywords: cloacogenic polyp, benign tumors, colonoscopy.

INTRODUCTION

Inflammatory cloacogenic polyps are rare lesions of unknown etiopathogeny, usually located in the anorectal transition zone, and are generally benign, although macroscopically they may appear malignant [1].

Rectal bleeding is the most common symptom; however, up to 20 % of patients may be asymptomatic [2]. We present a case of inflammatory cloacogenic polyp in a patient who has consulted for chronic rectorrhages.

Case report:

A 70-year-old man with alcohol and tobacco, type 2 diabetes for 20 years, hypertensive on treatment (calcium channel blocker for 14 years) cholecystectomized 10 years ago with no personal or family history of digestive or extradigestive neoplasia or chronic inflammatory bowel disease, who consults

for chronic rectorrhagia and rectal syndrome without any transit disorders or other associated digestive or extradigestive signs in a context of preservation of general condition and afebrile.

The proctological examination showed a raspberry pediculate polyp 3 cm long delivered at the anal margin, the rest of the physical examination is without particularity in particular no abdominal tenderness and no tumor syndrome or anemic syndrome.

At the hemoglobin balance 13 g/dl platelets at 368 k/Ul, a total colonoscopy was without abnormalities, a polypectomy with pathological study objectified an inflammatory cloacogenic polyp.

After resection of the polyp the patient becomes asymptomatic, since cloacogenic polyps are benign, we did not pursue other treatments.

Discussion:

The terms 'cloacogenic anal carcinoma', 'cloacogenic zone' and 'cloacal membrane' have been widely used, but the term 'inflammatory cloacogenic polyp' (IBP) was first applied and published by Lobert PF and Henry DA in 1981 [1]. They are single or multiple, more pedunculate than sessile, from 10 mm to 50 mm, located at the anorectal junction [3], can morphologically mimic hemorrhoid, solitary rectal ulcer, villous adenoma or anorectal carcinoma. Therefore, histopathological assessment is essential [4].

Histological results are a tubular growth model and irregularly shaped crypts moved into the submucosa, surrounded by a fibromuscular stroma [1].

Cloacogenic polyps are relatively more common in women in the fourth to sixth decades of life, although they have also been described in children [5]. Pathophysiology remains uncertain. Rectal bleeding is the most common clinical presentation but up to 20% of patients are asymptomatic. Other symptoms described are bowel movement disorders, bowel pain, tingling or anal pruritus [6].

These lesions tend to be located in the anorectal region and rectum (10-12 cm above the anus). However, polyps due to mucosal prolapse have been described at the rectosigmoid junction and in the sigmoid colon [7].

The size of these polyps is generally 1-5 cm and, although they are generally sessile, they can sometimes be pediculated. They may be multiple or solitary and coexist with sporadic hyperplastic or adenomatous polyps; it may be difficult to differentiate them from dysplastic lesions during colonoscopy. The size of the polyps and the hemorrhagic appearance may suggest malignant potential, and the appearance of squamous cell carcinoma on cloacogenic polyps has been described [8].

Inflammatory cloacogenic polyps have been reported in adults with various gastrointestinal disorders, including Crohn's disease, diverticulosis, colorectal tumors and hemorrhoids. However, a causal relationship between these diseases has not been identified. Inflammatory cloacogenic polyps have also been associated with dysplasia in the anus and anal intraepithelial neoplasia [5,9]. The human papilloma virus, regularly involved in anorectal neoplasms, is also linked to inflammatory cloacogenic polyps [9].

Treatment should aim to reduce the underlying spasm and eliminate polyps. A fiber-rich diet has been shown to be useful in regressing inflammatory polyps in some patients [10]. However, endoscopic or surgical resection of polyps is the treatment of choice when lesions produce symptoms or potential malignant potential cannot be excluded [11].

CONCLUSION

In conclusion, cloacogenic inflammatory polyps are lesions that must be considered in the differential diagnosis of polypoid lesions that may be observed during colonoscopy and, therefore, the endoscopist must be aware of them. The underlying pathogenic mechanism is unknown.

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