

Uncommon Mass of the Rectum: Colitis Cystica Profunda

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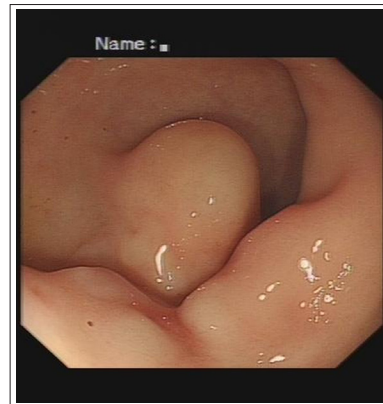
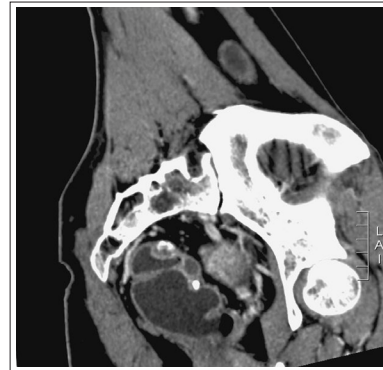
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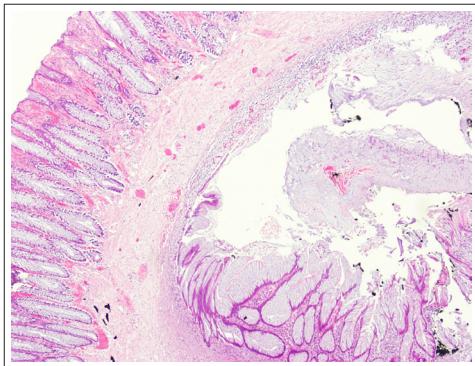
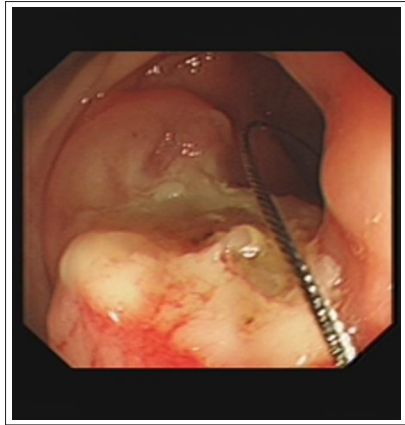
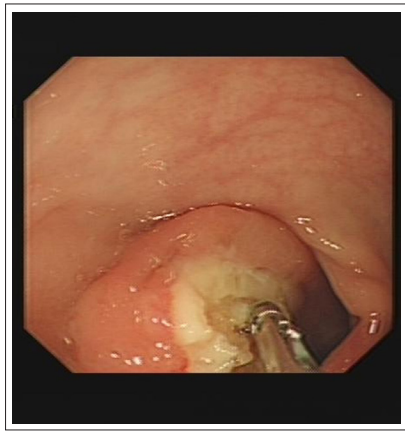
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Case Report

A 29-year-old woman was admitted to our hospital complaining of abdominal distention for one year, and occasionally experienced mild pain in the left lower abdomen. There was no antecedent or associated colonic disease. Physical examination didn't reveal any abnormality. All results of her hematological and biochemical tests were normal, including erythrocyte sedimentation rate, C-reactive protein, and carcinoma-embryonic antigen. Her abdominal CT scan revealed uneven thickening of the left anterior-lateral wall of the rectum without the loss of perirectal fatty tissue and multiple cystic masses associated with scattered calcification in the transition zone between the rectum and sigmoid (Figure A & B: oblique reconstructed images). There was no lymphadenopathy in the abdomen. Two colonoscopies showed multiple smooth sub mucosal masses ranging from 1.0cm x1.5cm to 2.0x2.5cm in size (Figure C). An endoscopic ultra-sonogram depicted a cystic mixed-echoic lesion without adjacent adenopathies (Figure D). The initial endoscopic biopsies were inconclusive. Endoscopy macrobiopsys were performed, and a mucoid and gelatinous material came out of it (Figure E & F). Macro biopsy specimen showed cystic lesion filled with muslin in the muscularis mucosa, and cystic wall was coated with columnar epithelium and inflammatory infiltrate (Figure G). The final diagnosis is colitis cystica profunda (CCP). The patient was recommended to high-fiber diet and regular lifestyle, and she remained well at the 1-year follow-up of endoscopy.





obtained through CT images, which also allow an evaluation of the full thickness of the bowel wall and the surrounding tissues. In our case, multiple cystic lesions together with scattered calcifications suggested a benign lesion on CT images, which narrowed the differential diagnosis to dermoid cysts, tuberculosis and tetradomic, but the final diagnosis is made on the pathological examination of endoscopic macro biopsy. Therefore, a close collaboration between CT images and endoscopy is vital for establishing the diagnosis and determine treatment strategies so as to avoid unnecessary surgical resection for CCP.

CCP is a chronic benign disorder, so treatment should begin with diet and lifestyle change such as avoiding constipation and straining in defecation [2]. Pharmacological therapy includes lubricants, bulking laxatives, hydrocortisone enemas, and sucralfate. However, patients with general affectation, lack of response or intestinal obstruction may be considered for surgery.

References

1. Bentley E, Chandrasoma P, Cohen H, Radin R, Ray M (1985) Colitis cystica profunda: presenting with complete intestinal obstruction and recurrence. *Gastroenterology* 89: 1157-1161.
2. Valenzuela M, Martin-Ruiz JL, Alvarez-Cienfuegos E, Antonio M. Caballero, Francisco Gallego, et al. (1996) Colitis cystica profunda: imaging diagnosis and conservative treatment. *Dis Colon Rectum* 39: 587-590.

CCP is a rare benign condition characterized by the presence of mucus collection in the sub mucosa layer, which results in single or multiple polypoid lesions. CCP frequently affects the rectum and left colon, occasionally involving the complete colon. Its etiology remain unclear, maybe associated with healing of the mucosa, inflammatory intestinal disease or isolated rectal ulcer [1]. Clinic symptoms of CCP lack specific manifestations. Similar to CCP, many enteric diseases that may arise deep to the mucosa within the wall of the large intestine can produce a focal sub mucosal abnormality. Under these circumstances, endoscopic studies in combination with CT images can provide confident evidences for differentiating no neoplastic entities from neoplasms, and both examinations can be performed on the same day without the need for additional bowel preparation. As known, colonoscopy allows only a visual evaluation of the surface of the intestinal lumen, including polypoidy or sessile lesions covered with normal, edematous or congestive mucosa, or ulcerated areas. Other information about the origin, internal composition, and extent of the lesion can be easily

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