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EDITOR'S QUIZ: GI SNAPSHOT

A polypoidal 'non-polyp' in the colon

INTRODUCTION

A 42-year-old Caucasian man presented with increased stool frequency and dyspeptic symptoms for which he had been prescribed lansoprazole. At colonoscopy he was found to have a 4-cm smooth polypoidal lesion in the transverse colon, adjacent to the hepatic flexure (figure 1). It was determined not to represent an adenoma and a CT colonogram was arranged, which found no extracolonic invasion but shed little further detail on the nature of the lesion in question.

A repeat colonoscopy, carried out with the intention to characterise the mass further with endoscopic ultrasound (EUS) imaging the mass was found to be soft and untethered. Based on his experience in upper gastrointestinal endoscopy the endosonographer purported a diagnosis and proceeded to aspirate the lesion under direct vision.

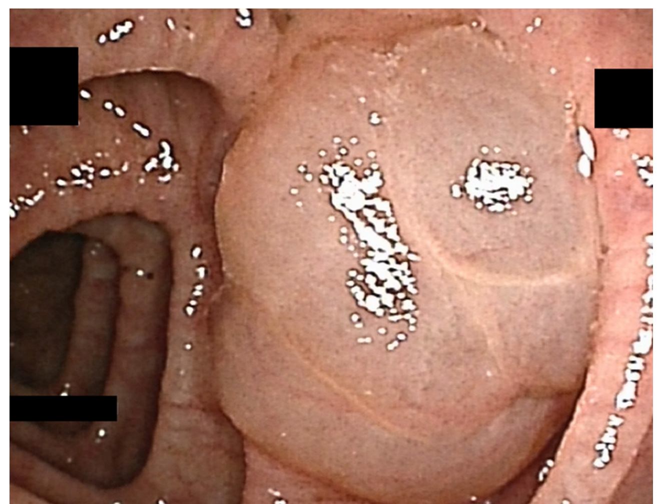

Figure 1 A sizeable smooth lesion arising from the epithelium at the transverse colon.

QUESTION

What is the diagnosis?

See page 1451 for answer

EDITOR'S QUIZ: GI SNAPSHOT

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See page 1381 for question

ANSWER

Microscopic analysis the specimen showed a mixed population of predominantly small mature lymphocytes, in keeping with the endoscopic impression of lymphangioma (figure 2).

Lymphangiomas are uncommon findings that tend to arise in the mesentery, omentum, mesocolon and retroperitoneum. Those arising in the colonic wall are even rarer and are prone to misdiagnosis as lipomas or adenomas. The typical endoscopic appearance of a cystic lymphangioma like this is of a smooth, subepithelial mass with the impression of a clear or translucent fluid within.[1] It develops from the proliferation of ectatic lymphatic vessels within the lamina propria.[2] The majority of lymphangiomas are asymptomatic but abdominal pain, change in bowel habit, gastrointestinal bleeding, obstruction and intussusception have all been documented as presenting features.[3] With no reliable predictors of progression to a problematic state, this somewhat poses a dilemma to the physician. Most reported cases reported have been managed conservatively however endoscopic or surgical resection have been reported, particularly for larger lesions that can cause local problems and the aforementioned symptoms.[4] EUS can be a useful tool for the diagnosis of colonic lymphangiomas and may obviate the requirement for biopsy/aspiration.[5] Incidentally, our patient's stool frequency normalised after a change from lansoprazole to esomeprazole. A further clinic review is planned, but there are no intentions to resect this lesion.

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Correction notice This article has been corrected since it published Online First. The question and answer headings have been added.

Contributors All authors contributed to the writing of this article and the care of the patient.

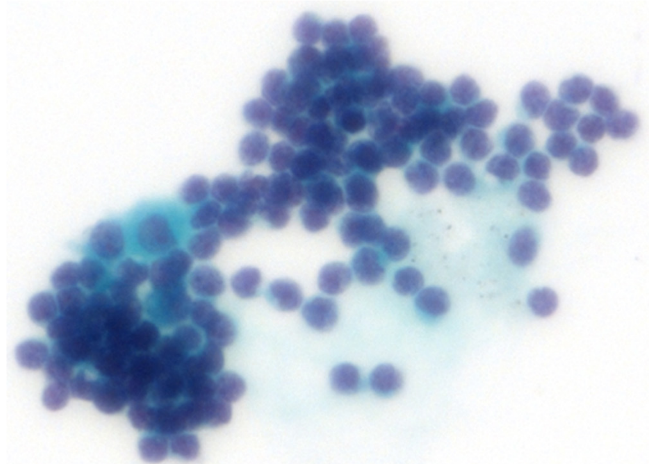

Figure 2 Collection of small mature lymphocytes in keeping with a diagnosis of lymphangioma.

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