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IMAGE | SMALL BOWEL

A Preponderance of Polyps: Sequelae of Familial Adenomatous Polyposis

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Case Report

A man in his fourth decade with familial adenomatous polyposis (FAP) and previous colectomy due to colon adenocarcinoma underwent esophagogastroduodenoscopy (EGD) to investigate 3 days of nausea, epigastric abdominal pain, and coffee ground emesis; no source of bleeding was found. During the endoscopy, patchy mucosal abnormalities throughout the duodenum were identified and biopsied (Figure 1). The abnormalities raised concern for duodenal polyposis. The polyps were innumerable and coalescent in appearance (Figure 2). Histology showed tubulovillous adenomas with low-grade dysplasia. According to Spigelman's classification, the patient had numerous circumferential (>20; 3 points), large (>10 mm; 3 points), and tubulovillous (2 points) duodenal polyposis with low-grade dysplasia (1 point).[1] The 9-point score corresponded to stage IV duodenal polyposis. He was discharged with plans for outpatient endoscopic ultrasound (EUS) of the duodenal polyposis; however, a few weeks later, he presented again with nausea and vomiting, and was admitted due to concerns for partial small bowel obstruction. Radial EUS evaluation of these circumferential duodenal polyps revealed mucosal involvement without deeper invasion. Nodes sampled during EUS were adenocarcinoma with histologic appearance similar to his former colorectal adenocarcinoma, suggesting a metastatic etiology, not a new primary duodenal cancer. Due to the complicated hospital course and the extent of his metastatic disease, the patient opted for palliative care and passed away shortly thereafter.

Approximately 75% of patients with duodenal polyposis progress in stage, and those with stage III or IV adenomas have a 44% risk of developing duodenojejunal cancer.[2] Advanced stage duodenal polyposis is not rare, and in a prospective cohort of FAP patients, 40% are estimated to reach stage IV by age 60 years, and 50% by age 70 years. For advanced adenomas, defined as

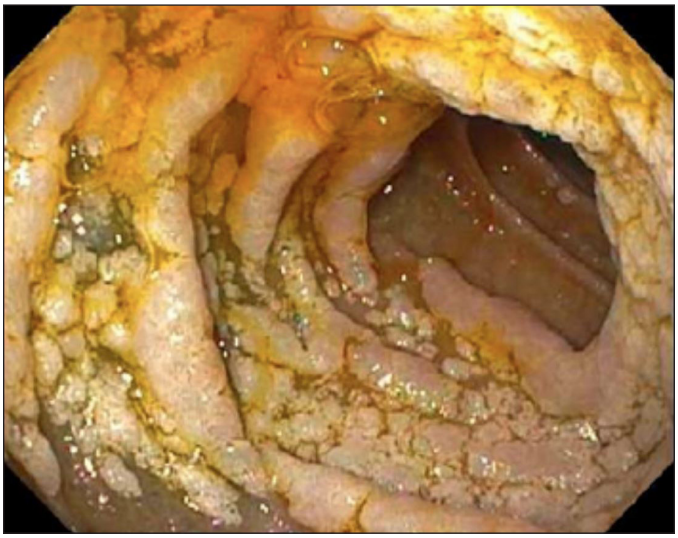

Figure 1. EGD during first hospitalization showing patchy mucosal abnormalities in the second segment of the duodenum.

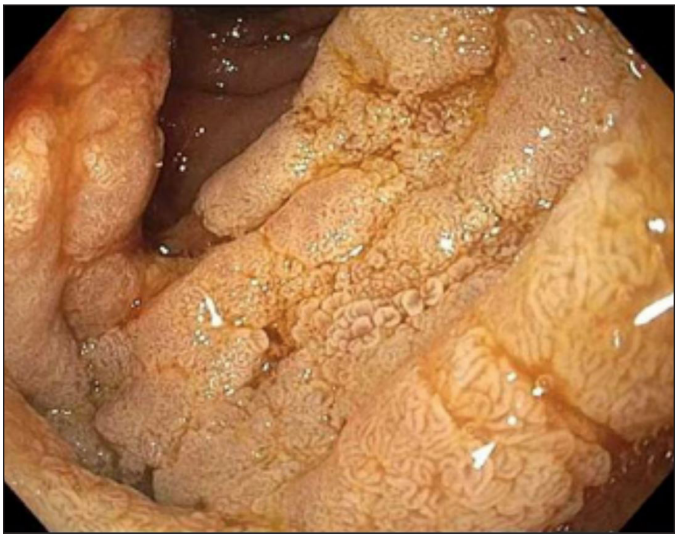

Figure 2. Coalescent-appearing duodenal polyps in the second segment of the duodenum shown on EGD.

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larger than 10 mm or with high-grade dysplasia, current recommendations include referral for endoscopic treatment via mucosectomy or routine follow-up until the patient develops stage IV duodenal polyposis or duodenal carcinoma, at which point pancreaticoduodenectomy is appropriate.[3]

Disclosures

Author contributions: S. Assalita wrote the article. M. Latifi and I. Hanouneh edited the manuscript and supervised the process. I. Hanouneh is the article guarantor.

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Informed consent: The patient is deceased, and multiple attempts to contact the patient's next of kin for informed consent were unsuccessful. All patient identifying information has been removed.

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