A Bloody Polyp in the Sigmoid Colon

Mónica Garrido,¹ Olinda Lima,² and Luís Maia¹

¹Department of Gastroenterology, Hospital de Santo António, Centro Hospitalar Universitário do Porto, Porto, Portugal; ²Department of Pathology, Hospital de Santo António, Centro Hospitalar Universitário do Porto, Porto, Portugal

**Question:** A 64-year-old Caucasian man was referred to our hospital for iron deficiency anemia. His past medical history was significant for previous smoking, hypertension, diabetes mellitus, dyslipidemia, noncirrhotic JAK2 mutation-related portal vein thrombosis with portal hypertension, and prostate adenocarcinoma. Physical examination was unremarkable. Laboratory data included a hemoglobin of 12.5 g/dL (reference range, 13–17 g/dL), a mean corpuscular volume of 62 fL (reference range, 83–101 fL), and a mean corpuscular hemoglobin of 20.8 pg (reference range, 27–32 pg). Platelets and coagulation profile were normal.

During an anemia workup, a colonoscopy showed a pedunculated polyp in the sigmoid colon, with a short wide stalk and a lobulated and reddish head with an adherent whitish deposit, measuring 14 mm (Figure A). The polyp was resected with a hot snare after prophylactic placement of an Endoclip in the stalk.

What is the diagnosis of this lesion?

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**Correspondence**
Address correspondence to: Mónica Garrido, MD, Gastroenterology Department, Centro Hospitalar e Universitário do Porto, Largo Prof. Abel Salazar 4099-001 Porto, Portugal. e-mail: monicasofigarrido@gmail.com.

**Conflicts of interest**
The authors disclose no conflicts.

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0016-5085/$36.00
https://doi.org/10.1053/j.gastro.2020.01.016
Histologic examination revealed a lobular proliferation of variably sized capillaries surrounded by an edematous stroma with inflammatory cells (Figure B; stain: hematoxylin and eosin; original magnification ×40), consistent with the diagnosis of a lobular capillary hemangioma (LCH). One year later, the patient is asymptomatic, with normal hemoglobin and iron levels.

LCH, also known as pyogenic granuloma, is a benign vascular lesion that typically affects the skin and mucosal surfaces, but rarely the gastrointestinal tract.1 Up to 70 case reports of gastrointestinal LCH have been described2 and an additional 23 cases were reported from a single-center pathologic specimens review over a 10-year period (approximately 1/10,000 endoscopies),1 which raises the possibility that the actual incidence is probably much higher but unrecognized.

LCH pathogenesis is unclear; besides trauma and hormonal influences, another proposed precipitating factor is portal hypertension, as observed in our patient, probably secondary to venous stasis and retrograde dilation of capillary blood vessels.2

The median age at diagnosis is 59–64 years, with an almost equal sex distribution.1,2 The most reported anatomical locations are the esophagus2 and the sigmoid colon.1 Most lesions are incident findings during endoscopic studies for unrelated reasons.1 When symptomatic, the most common manifestation is anemia,2 some with overt bleeding.2 Endoscopically, most lesions show a smooth surface, with a bluish to red color and a superficial white or opaque film covering,2 which can mimic colon cancer, highlighting the importance of histology for definitive diagnosis. In some cases, they can grow quickly but usually are <20 mm and involve only the mucosa,2 which makes these lesions amenable to endoscopic resection. Owing to its vascular nature, postpolypectomy hemostasis is usually necessary.3 Recurrence is rare.2

Although LCH are rare and devoid of malignant potential, overdiagnosis and overtreatment as a malignant tumor, as well as postresection bleeding, may be prevented if LCH is readily recognized.

Keywords: Lobular capillary hemangioma; Pyogenic granuloma; Colon.

References