Autoamputation of Colonic Polyp

Devendra Singh
Department of Gastroenterology, Apollo Hospitals, Bilaspur, Chhattisgarh, India

ABSTRACT

Autoamputation of colonic polyps in children is well known, but is extremely rare in adults. Its precise mechanism remains imperfectly understood. We present a 46-year-old woman who had a large polyp at the junction of sigmoid and descending colon occupying more than three fourth of colon lumen. One day after forcep biopsies were taken, she developed severe colicky pain abdomen, rectal bleeding and passed some fleshy material per anum which was confirmed to be self amputated polyp. It is possible that amputation may follow colonic injury induced by excessive peristalsis following bowel preparation and forceps biopsy. (J Dig Endosc 2011;2(4):236-38)

Key words: Autoamputation - Large colonic polyp - Bowel preparation.

Introduction

Autoamputation of gastrointestinal polyps is known to occur. Most of the polyps in which autoamputation is reported, whether benign or malignant have been smaller in size. Moreover, the factors associated with autoamputation are also not clearly known. We report a case of autoamputation of colonic polyp which was 9 cms in length and occurred soon after bowel preparation for colonoscopy.

Case report

A 46-year-old lady who was on regular medication for hypertension for 7 years, presented with history of incomplete bowel evacuation and intermitted passage of blood tinged stools. Bowel symptoms used to improve with ispaghula husk temporarily. She did not report pain abdomen or loss of body weight. Clinical examination was unremarkable. Laboratory investigations revealed the following results: haemoglobin, 11.7gm/dl, total leucocyte count, 9100/cmm, and platelet count-3.27 lakhs/cmm. She was advised colonoscopy, which was done after preparation with sodium phosphate (Exelyte). Colonoscopy revealed a large polyp at the junction of sigmoid and descending colon occupying more than three fourth of colon lumen (Figure 1). The surface of the polyp was ulcerated. Colonoscope could not be passed beyond the polyp into proximal colon even after changing patient’s position from left lateral to supine.
and right lateral. Multiple biopsies were taken from the surface of the polyp and she was asked to report after 3 days later. She returned home which is about 300 miles away from this hospital.

The next day she experienced acute severe colicky pain abdomen lasting several minutes. During pain she had an urge to defecate and passed some fleshy material per anum. This was followed by subsidence of pain but she had multiple episodes of haematochezia which she reported telephonically. She was asked to put the fleshy substance in a formalin container and report to local hospital in her place. She reached this hospital the next day and was found to have pallor and tachycardia, but was comfortable otherwise.

The collected specimen was 9cm long including one cm long stalk, polypoidal in appearance and resembled the endoscopically seen colonic polyp. Sigmoidoscopy was done the same day. Rectum and sigmoid colon contained fresh blood (Figure 2). Multiple blood clots were present proximal to sigmoid descending junction and these could not be washed off completely. An oblong lesion with ragged margins was seen at the site where polyp was seen during previous endoscopy. However, there was no active bleeding from the site. Saline was injected around the lesion as a precautionary measure.

She stabilised over next 2 days without blood transfusion and passed normal stool. Full colonoscopy was done 2 days later which revealed a smooth and healing remnant of polyp near sigmoid-descending junction (Figures 3 and 4). Proximal colon contained no synchronous polyp. Histopathology of the endoscopic biopsy and spontaneously passed specimen both revealed adenomatous polyp (Figure 5). Patient was discharged home the next day.

Discussion

Autoamputation of colonic polyps in children is well known, but is extremely rare in adults[1-3]. Juvenile polyps typically outgrow their blood supply and may autoamputate some time during or after puberty[1] followed by haematochezia which may be mild to severe [4]. Most of the reported cases of autoamputation were of smaller size. Our case had relatively large size polyp but surprisingly had only subtle symptoms. This may be due to shy nature and under reporting of symptoms by females in many orthodox Indian families. Moreover, temporal relation of auto amputation to colonoscopy is also interesting. Perhaps multiple bowel movements during bowel preparation may have led to tension of the stalk of the polyp leading to vascular compromise and autoamputation. Similar possibility has been suggested in some other case reports[3]. At the same time multiple attempts to push the colonoscope across the polyp during first colonoscopy may have stretched the polyp causing some additional injury to the stalk. Although owing to the large polyp size our case had a potential risk of massive
blood loss fortunately she had only moderate bleed and could be salvaged easily. Thus, autoamputation of polyps in adults although rare can occur. Enhanced peristalsis during bowel preparation may have played a role in autoamputation in our case.

References


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