

A Rare Case of Sigmoid Leiomyoma Disguised as a Polyp

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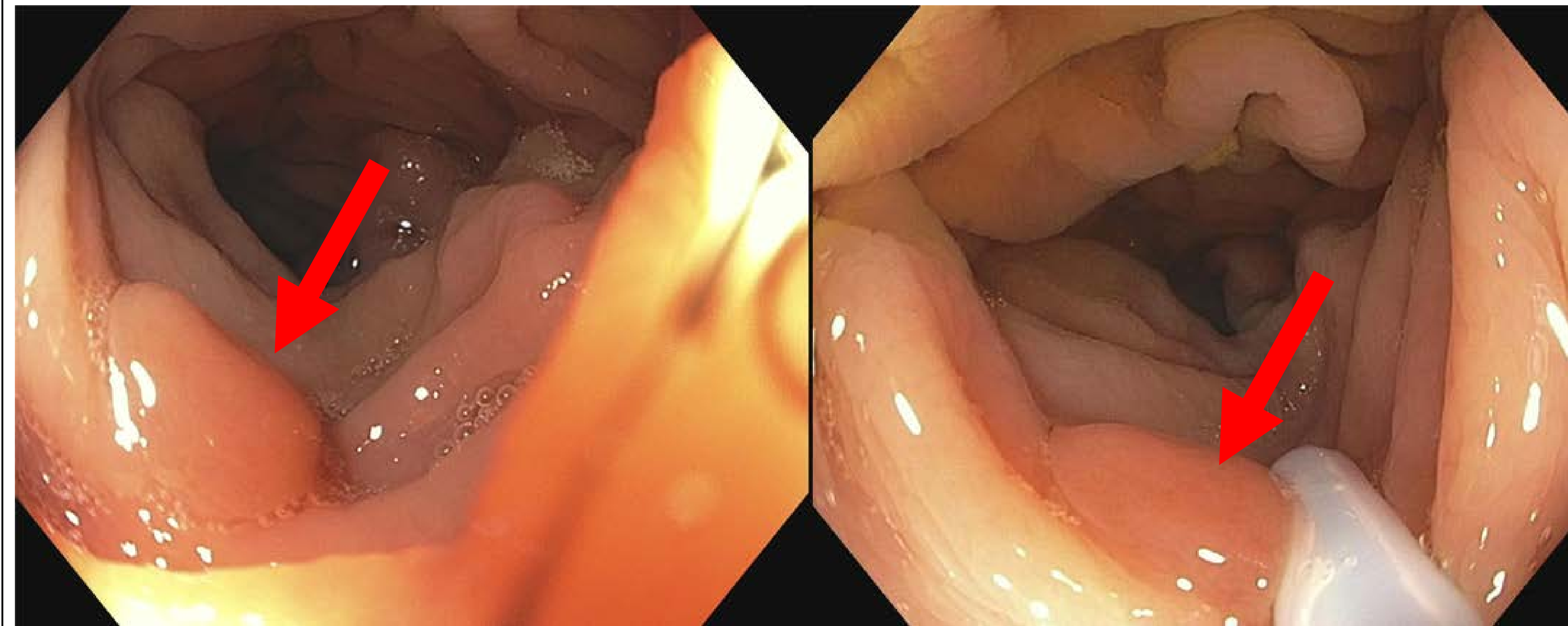
Introduction

Colonic leiomyomas are smooth muscle tumors which arise from either the muscularis mucosa or the proper muscle layer. Colonic and rectal leiomyomas are rare tumors and represent only about 3% of all gastrointestinal leiomyomas. Most patients are asymptomatic; however, some can have symptoms of abdominal pain, intestinal obstruction, hemorrhage, and perforation when the leiomyoma is of larger size. We present a case of sigmoid leiomyoma encountered on routine colonoscopy.

Case Discussion

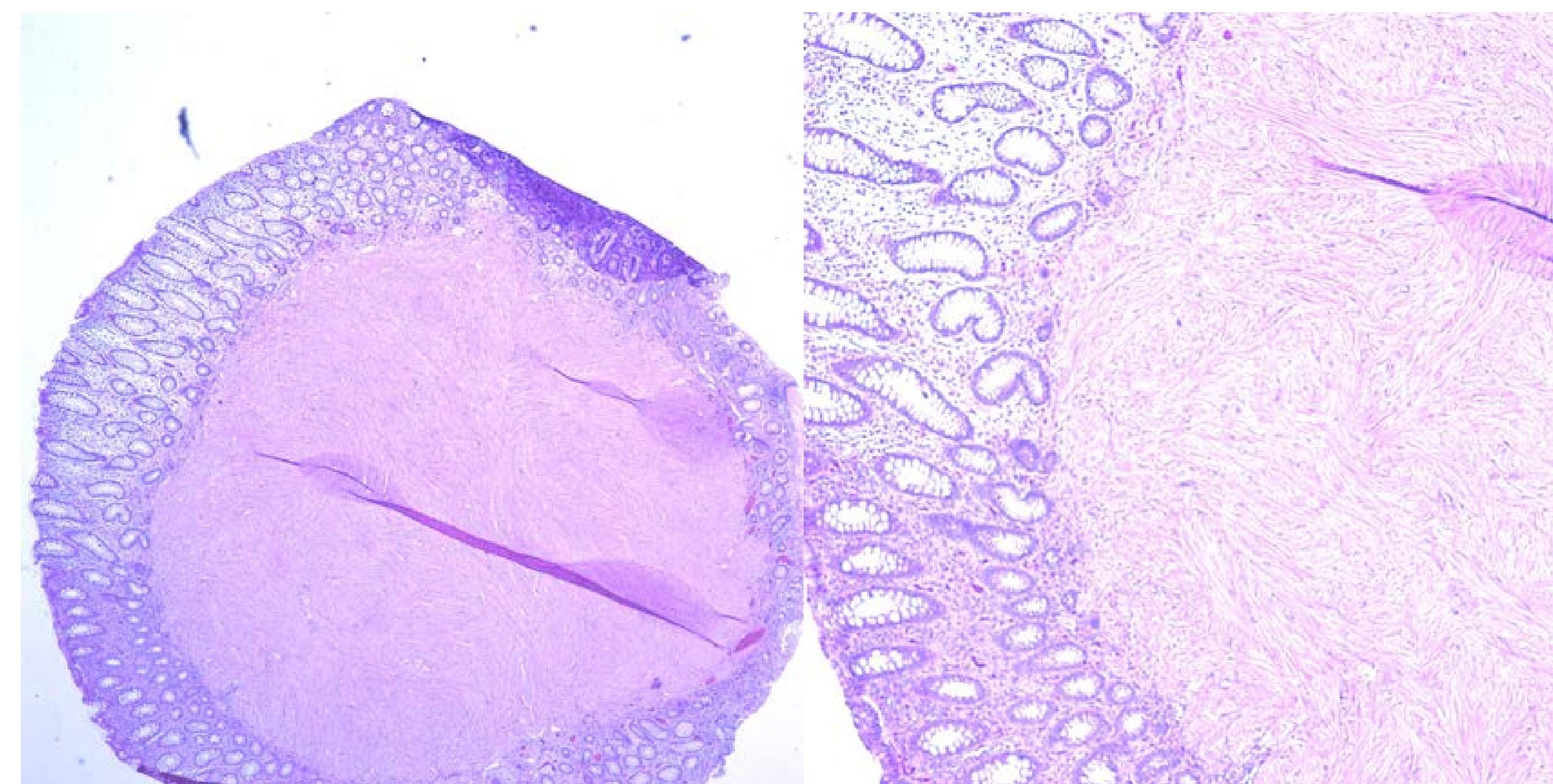
A 52-year-old man from Ecuador with a past medical history of hypertension, gastritis, osteoarthritis of the knees, presented to the clinic for evaluation of GERD symptoms. He was also due for repeat colonoscopy for surveillance of colon polyps. He underwent routine EGD and colonoscopy. EGD findings and biopsies of the stomach were unremarkable. The patient underwent a colonoscopy and was found to have an 8mm sessile polyp seen in the sigmoid colon. The polyp was resected with cold snare and sent to pathology. The bowel preparation was excellent. Pathology revealed colonic mucosa containing smooth muscle proliferation. Immunostain with smooth muscle actin (SMA) supported the diagnosis.

Endoscopy Images

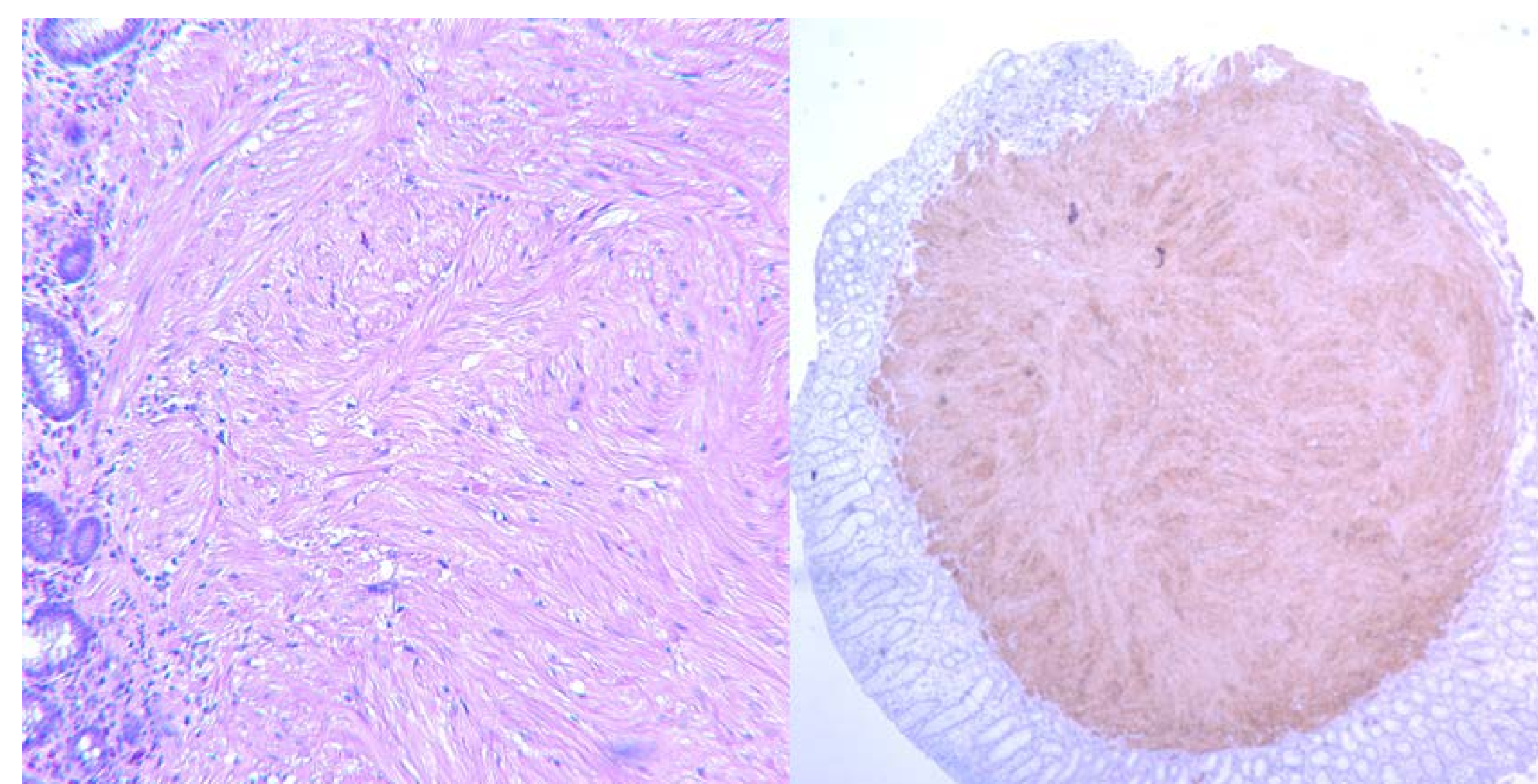


Endoscopic images of leiomyoma

Pathology Images



Low power H&E stain of leiomyoma



High power H&E stain of leiomyoma and SMA stain.

Discussion

Leiomyomas have been first described by Virchow in 1854. They are usually considered benign and arise in the uterus, but may also be found in the skin, nipple, scrotum, and labia. Leiomyomas are less frequently encountered in the GI tract, and when found, are primarily seen in the esophagus or stomach. The management of leiomyomas is surgical resection, however, with the evolving field of gastroenterology, endoscopic removal is considered an alternative for resection. Given leiomyomas arise from the muscularis mucosa or the proper muscle layer, endoscopic resection represents a higher risk of perforation. Submucosal injection technique can be used to identify which layer the leiomyoma arises from. If the lesion cannot be lifted using a submucosal injection of saline, the lesion may have deep submucosal invasion or can originate from the proper muscle layer. This risk for perforation is higher when the leiomyoma arises from the proper muscle layer and it is a contraindication to endoscopic removal. We represent a rare case of sigmoid leiomyoma which was removed using endoscopic technique without any complication of perforation or bleeding.

References

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2. Choi HH, Cho Y, Choi SK, Kim H, Kim SS, Chae H, Shin O. **Clinical Outcomes of Endoscopic Removal in Patients with Colorectal Polypoid Leiomyomas.** *Korean J Gastroenterol* 2016;68:179-185.