INSIDE VIEW

Pedunculated polyp of the ileum protruding from a large diverticulum

INTRODUCTION

A 52-year-old woman presented with iron deficiency anaemia and postprandial right lower quadrant pain. Abdominal examination was unremarkable and laboratory results showed mild anaemia (haemoglobin 11.3 g/dL). Upper and lower endoscopies did not reveal any source of bleeding. Video capsule endoscopy was performed which showed a large polypoid lesion in the mid-ileum ([figure 1](#)). Abdominal contrast enhanced CT demonstrated a heterogeneously enhancing pedunculated polyp measuring approximately 6 cm ([figure 2](#)). Retrograde double-balloon enteroscopy was performed which revealed a large pedunculated polyp with hyperplastic-like mucosa protruding from a large diverticulum located approximately 70 cm proximal to the ileocaecal valve ([figure 3A](#)). The stalk appeared to arise from the base of the diverticulum ([figure 3B](#)). A technetium-99m pertechnetate scintigraphy revealed no ectopic gastric mucosa.

QUESTION

What is the diagnosis?

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Figure 1 Video capsule endoscopy shows a large polypoid lesion.

Figure 2 CT shows a heterogeneously enhancing pedunculated polyp (arrow).

Figure 3 Retrograde double-balloon enteroscopy images. (A) Large pedunculated polyp protruding from a large diverticulum. (B) The stalk appears to arise from the base of the diverticulum.

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ANSWER

The patient underwent laparoscopic small bowel resection. Gross examination revealed a polypoid mass protruding into the lumen of the small bowel (figure 4). Histological sections from the mass showed that the surface consisted of benign small intestinal mucosa with reactive changes and mucosal prolapse-like features, but the central core of the polyp comprised all layers of the small bowel wall (submucosa, muscularis propria and subserosal adipose tissue) in a configuration consistent with an inverted Meckel's diverticulum

Figure 4 Gross examination reveals a polypoid mass protruding into the lumen (arrow).

Figure 5 Histological findings are consistent with an inverted Meckel's diverticulum.

(figure 5). Areas of pyloric metaplasia were identified, but no convincing heterotopic elements were seen. After surgery, her anaemia resolved.

Inverted Meckel's diverticulum was thought to be rare; however, a study has reported that 21% of cases of Meckel's diverticulum are found to be inverted into the small bowel lumen.¹ Although it is difficult to diagnose preoperatively, inverted Meckel's diverticulum should be considered as a differential diagnosis for any pedunculated polyp in the distal ileum because endoscopic resection may result in iatrogenic perforation.² However, with the aid of closure devices such as clips or detachable snares, endoscopic resection of inverted Meckel's diverticulum can be successfully achieved.^{3,4}

Yugo Iwaya,¹ Corwyn Rowsell,² Teodor Grantcharov,³ Norman E Marcon¹

¹Division of Gastroenterology, St Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

²Division of Laboratory Medicine, St Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

³Division of General Surgery, St Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

Correspondence to Dr Yugo Iwaya, Division of Gastroenterology, St Michael's Hospital, University of Toronto, Toronto, ON M5B 1W8, Canada; yiwaya@shinshu-u.ac.jp

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