Anal intraepithelial neoplasia in an inflammatory cloacogenic polyp

I M Hanson, G R Armstrong

Abstract
A rare case of anal intraepithelial neoplasia arising in an inflammatory cloacogenic polyp is reported. While the occurrence of neoplasia complicating benign anal conditions is recognised, this case re-emphasises the need for careful histological examination of all perianal lesions.

Case report
A 34 year old woman presented with a two month history of recurrent rectal bleeding and passage of mucus. She had suffered similar symptoms episodically over the previous six years, and had had four endoscopic resections of polyps from just above the dentate line of the anal canal from various circumferential positions. These had been diagnosed histologically as inflammatory in nature, showing features of the mucosal prolapse syndrome. In 1991, colonoscopy as far as the caecum had been otherwise normal. At sigmoidoscopy this time, a soft fleshy polyp was visualised posteriorly and resected. No other anorectal abnormality was seen.

GROSS EXAMINATION
The polyp measured 0.7 cm in its greatest axis, and was brown and soft in consistency.

MICROSCOPIC EXAMINATION
Histologically, the polyp had the typical architectural features of an inflammatory cloacogenic polyp (fig 1). Within the stroma, there was central splaying of fibres of the muscularis mucosae and fibromuscular obliteration of the lamina propria. Large intestinal type glands were irregularly placed peripherally, many distorted and branching, some cystically dilated and hyperplastic. There was a moderate active chronic inflammatory cell infiltrate with focal superficial ulceration. In addition, much of the surface epithelium of the polyp was covered by stratified squamous epithelium, in which there was moderate and severe squamous intraepithelial neoplasia (fig 2). This dysplastic epithelium extended into some of the superficial large intestinal glands but there was no evidence of invasive neoplasia. There was overlying parakeratosis, many dyskeratotic cells, occasional multinucleate forms, and focal koilocytic atypia, suggestive of human papillomavirus (HPV) infection. Non-polypoidal mucosa was not submitted, although at one diathermied margin there was some anal transitional zone tissue.

A cervical smear taken following these histological findings has shown features of HPV infection and mild squamous dyskaryosis.
Discussion

The presence of squamous epithelium with HPV related features in an inflammatory cloacogenic polyp has been reported only once before, and in that case foci of mild and moderate squamous dysplasia were noted. Our case represents a second, more florid example of this probably coincidental association.

The association of benign anal lesions with anal neoplasia has been investigated in several studies. In a large population based Danish study, 0.03% of patients receiving treatment for fissures, fistulas, abscesses, and haemorrhoids subsequently developed anal squamous cell carcinoma, and the association was not thought to be causal. The incidental finding of anal intraepithelial neoplasia within haemorrhoidal specimens was studied by Foust et al. Nineteen cases were identified over a 22 year period, frequently associated with HPV infection as detected by in situ hybridisation. Recurrence was uncommon (one case) and haemorrhoidectomy curative after a mean six year follow up.

Although the natural history of anal intraepithelial neoplasia within haemorrhoidal specimens was studied by Foust et al., Nineteen cases were identified over a 22 year period, frequently associated with HPV infection as detected by in situ hybridisation. Recurrence was uncommon (one case) and haemorrhoidectomy curative after a mean six year follow up.

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