

Endoscopic treatment of a giant pedunculated angiolipofibroma of the distal duodenum



Fig. 1 A giant polyp immediately after endoscopic polypectomy and its retrieval for histology. Note the large-caliber central vessel.



Fig. 2 Longitudinal section of the angiolipofibroma after its fixation in 10% buffered neutral formalin. Note the large caliber of the vessels.

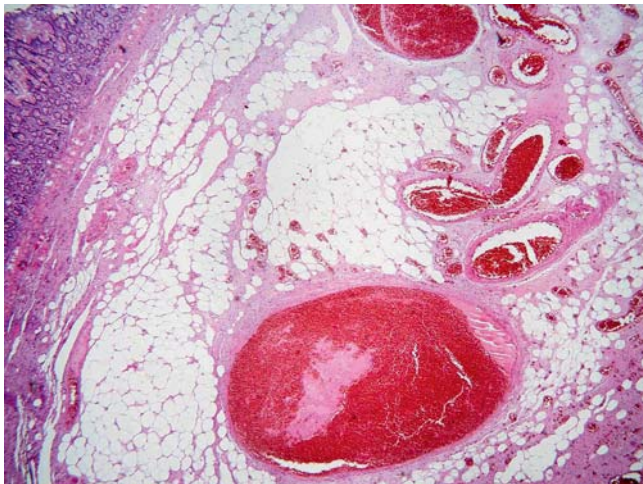


Fig. 3 Histology of angiolipofibroma. A well-demarcated lesion underlies the mucosa. The neoplasm is composed of fat, fibrous tissue, and prominent congested vessels. (Hematoxylin and eosin staining; original magnification $\times 100$.)

Dual antiplatelet therapy (with clopidogrel and aspirin) may be complicated by severe gastrointestinal bleeding [1]. It may unmask an underlying pathology that has been silent so far. Small intestinal bleeding is the most frequent indication for double-balloon enteroscopy (DBE), both for diagnosis and treatment [2,3]. DBE is feasible even for polypectomy of large small-intestinal polyps (e.g. hamar-

tomas) [4]. We present an unusual case of successful endoscopic removal of a giant angiolipofibroma.

A 73-year-old man on dual antiaggregation therapy was investigated because of recurrent gastrointestinal bleeding requiring repeated blood transfusions (8 units over 3 months). The patient underwent gastroscopy and colonoscopy elsewhere with normal findings, and capsule

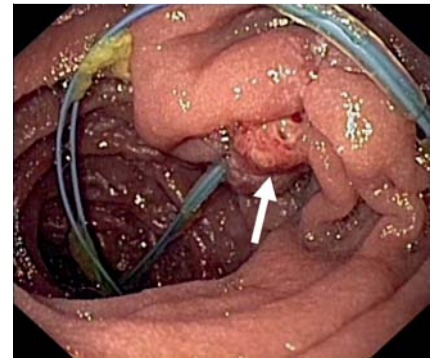


Fig. 4 Control endoscopy 9 days after polypectomy. The healing base is seen in the distal duodenum (arrow), one Endoloop is still in the right position.

enteroscopy with suspicion of small-bowel arteriovenous malformations (AVMs). He was subsequently referred to our department for DBE. However, no AVMs were revealed at DBE. Surprisingly, a finger-like giant polyp growing from the distal part of the duodenum reaching the proximal jejunum was found. The length of the polyp was 12 cm and its diameter 2 cm. Because of the patient's serious comorbidity, we decided to remove the polyp endoscopically (Video 1).

The polyp was extracted for histology (Figs. 1 and 2).

The final diagnosis was angiolipofibroma (Fig. 3).

There were no complications after the procedure (Fig. 4) and subsequent follow-up was uneventful.

Angiolipofibroma of the gastrointestinal tract is extremely rare. We found only one similar case in the available literature [5]. A giant pedunculated angiolipofibroma of the esophagus in a 62-year-old patient caused slowly deteriorating dysphagia but did not bleed. This was diagnosed by computed tomography and resolved by surgery [5].

Endoscopic polypectomy of giant small-intestinal polyps is a possible alternative to surgery in polymorbid patients. An experienced endoscopist, a safe design of the procedure, and preventive measures (availability of appropriate urgent surgery in case of complications) are necessary conditions.

Video 1

An Endoloop was put over the polyp and secured by two clips. Pure coagulation current was used for cutting. Polypectomy took 8 minutes. Mild bleeding was controlled by another two Endoloops placed on the base and additional argon plasma coagulation.

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