A computed tomography scan of the abdomen revealed asymmetric thickening in the caecum, whereupon a colonoscopy was ordered. It showed an ulcerated tumour occupying the entire caecum, with no abnormalities in the rest of the mucosa (Fig. 1, Image A). The biopsies were inconclusive as regards malignancy. A second colonoscopy was performed (Fig. 1, Images B and C), in which new samples were taken. This time, the immunohistochemical study showed the biopsies to be positive for cytomegalovirus, but not for dysplasia or carcinoma. Serology was positive for cytomegalovirus IgG.

The patient was treated with a 21-day course of oral valganciclovir, 900 mg every 24 h. A repeat colonoscopy two weeks after completion of treatment to assess endoscopic response and ensure healing revealed that the pseudotumour had completely disappeared (Fig. 1, Image D). The patient is currently asymptomatic.

The patient was investigated for possible immunosuppressive factors, but no disease or condition suggestive of a state of immunosuppression were found.

Cytomegalovirus infection can affect any part of the gastrointestinal tract. It is much more likely in patients with HIV, history of transplantation, use of corticosteroids, inflammatory bowel disease or chemotherapy treatment. Among immunocompetent patients, use of corticosteroids and transfusion of blood derivatives have been identified as risk factors for cytomegalovirus colitis.[1] Its incidence also increases with age, due to a reduced capacity for action on the part of T cells.

The usual symptoms are abdominal pain and diarrhoea, and up to half of patients may develop rectal bleeding or haematochezia. Endoscopic findings are non-specific.[2] A diagnosis should be based on observation of inclusion bodies in non-neoplastic mucosa cells with haematoxylin and eosin staining, and supported by immunohistochemical techniques using monoclonal antibodies. Approximately two-thirds of patients have positive serology.

The most common endoscopic presentation consists of well-defined ulcers and pseudomembranes, but in rare cases, it can appear as a newly formed mass,[3,4] in which case, colon cancer must be ruled out.

The treatment of cytomegalovirus colitis is not well established in current guidelines, particularly in immunocompetent patients with no comorbidities, such as our patient.[5] Given his good general condition, he was prescribed oral treatment and therefore could be followed up on an outpatient basis with no need to admit him.

References

1. Ko JH, Peck KR, Lee WJ, Lee JY, Cho SY, Ha YE, et al. Clinical presentation and risk factors for cytomegalovirus colitis in immunocompetent adult patients. Clin Infect Dis. 2015;60:e20–6, http://dx.doi.org/10.1093/cid/ciu969. Epub 2014 Dec 1. PMID: 25452594.
2. Suzuki H, Kato J, Kuriyama M, Hiraoka S, Kuwaki K, Yamamoto K. Specific endoscopic features of ulcerative colitis complicated by cytomegalovirus infection. World J Gastroenterol. 2010;16:1245–51.
3. Falagas ME, Griffiths J, Prekezes J, Worthington M. Cytomegalovirus colitis mimicking colon carcinoma in an HIV-negative patient with chronic renal failure. Am J Gastroenterol. 1996;91:168–9. PMID: 8561127.
4. Lima M, Matos AP, Ramalho M. Cytomegalovirus pseudotumor of the colon in an HIV patient. Radiol Case Rep. 2018;14:273–7, http://dx.doi.org/10.1016/j.radcr.2018.11.009. PMID: 30510610; PMCID: PMC6262821.
5. Yagel O, Israel S, Muszkat M, Ackerman Z, Szalat A. Challenges in the diagnosis of cytomegalovirus colitis in a presumed immunocompetent patient: interpretation of clinical condition, tissue, and serum cytomegalovirus polymerase chain reaction findings. Isr Med Assoc J. 2018;20:194–6. PMID: 29527862.

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Schwann cell hamartoma as an incidental finding in a colonoscopy

Hamartoma de células de Schwann como hallazgo incidental en una colonoscopia

Dear Editor,

We report a case of a 39-year-old male who underwent a colonoscopy after an episode of acute diverticulitis without other relevant medical or family history. In the descending colon an 8 mm sessile polyp (Paris 0-Is, NICE 1) was removed. Histopathological analysis revealed proliferation of spindle cells in the colonic mucosa without atypia (Fig. 1). With immunohistochemistry these cells displayed positivity for S-100 and CD-34, all of it being compatible with a benign mesenchymal polyp with a suggestive Schwann cell hamartoma phenotype (Fig. 1).

Discussion: In a study based on series of colorectal lesions composed by Schwamm cell proliferation in 2009, a new lesion named Schwann cell hamartoma was described. Schwann cell hamartomas are rare colorectal polyps with a mesenchymal origin.[1] 90% of the gastrointestinal hamartomas are gastric and rarely in the colon.[2] They consist of pure Schwann cells with S-100 protein immunoreactivity proliferation in the lamina propria.[1] In the majority of cases they are incidental endoscopic findings ranging between 1 and 6 mm in size and they usually occur in women of middle age, in the left colon.[3] They are considered benign polyps and have not demonstrated any association with inherited syndromes.[3] It is important to differentiate this polyp from other mesenchymal lesions (neurofibromas, ganglioneuromas, perineuromas or schwannomas) that do tend

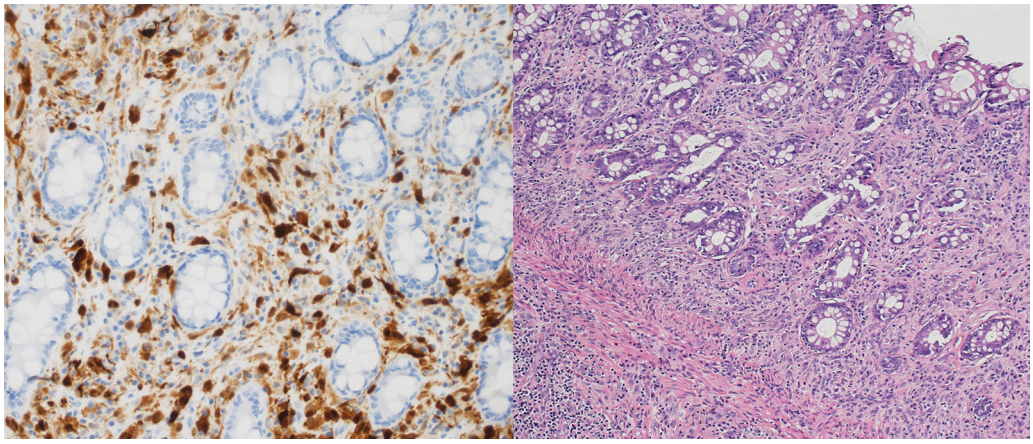

Figure 1 Histological staining showed a colonic polyp with mucosal proliferation of spindle cells without atypia (right side of the figure). The colon biopsy displayed with immunohistochemistry proliferated cells with positivity for S-100 and CD-34 (left side of the figure).

to be associated with inherited syndromes such as Cowden syndrome, multiple endocrine neoplasia 2b (MEN-2b) and neurofibromatosis type 1 as well as from others with malignant potential such as gastrointestinal stromal tumours (GIST).[1,4] Schwann cell hamartomas are a rare entity with an uncertain clinical significance. Further studies are needed in order to increase our knowledge on these lesions, mainly on establishing the appropriate follow up, as well as its possible nature as component of an unknown inherited syndrome. A careful histological assessment is mandatory to avoid mislabelling patients with malignant potential lesions or with inherited syndromes.

References

1. Gibson JA, Hornick JL. Mucosal Schwann cell ''hamartoma'': clinicopathologic study of 26 neural colorectal polyps distinct from neurofibromas and mucosal neuromas. Am J Surg Pathol. 2009;33:781–7.
2. Rocco EG, Iannuzzi F, Dell'Era A, Falleni M, Moneghini L, Di Nuovo F, et al. Schwann cell hamartoma: case report. BMC Gastroenterol. 2011;11:68.
3. Klair JS, Girotra M, Agarwal A, Aduli F. Mucosal Schwann cell hamartoma: just benign or more? Int J Colorectal Dis. 2014;29:1597–8.
4. Pasquini P, Baiocchini A, Falasca L, Annibali D, Gimbo G, Pace F, et al. Mucosal Schwann cell ''Hamartoma'': a new entity? World J Gastroenterol. 2009;15:2287–9.

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