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IMAGE OF THE MONTH

Beware of cecal mucus: Interval appendix rest sessile serrated adenoma/polyp (SSA/P) without dysplasia

Cuidado con la mucosidad cecal: intervalo apéndice resto adenoma/pólipo serrado sésil (SSA/P) sin displasia

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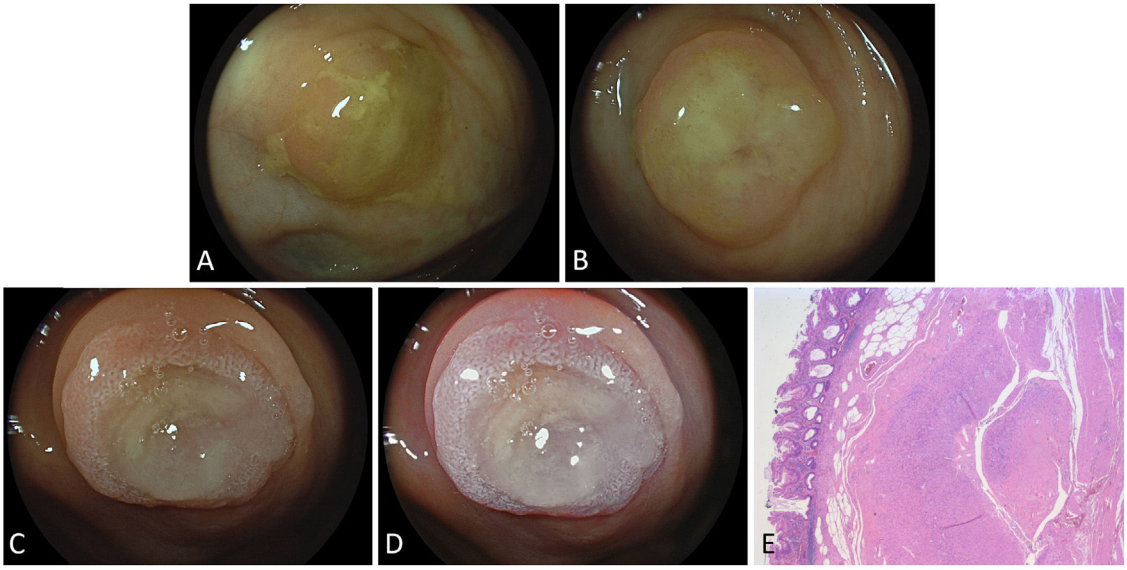

Figure 1 (A) The ''*cecal mucus sign*'' obscuring endoscopic visualization of the appendix rest, (B) unrelentingly defying water jet cleansing. (C) Clear-cut lesion margins and highlighting of mucosal pathology after intensive washing followed by ancillary spraying of 1% acetic acid on white light imaging. (D) Image-enhanced endoscopy using linked colour imaging highlights features of an SSA/P lesion with ''*dark spots inside crypts*'' as per WASP classification reflective of dilated crypt openings. An uncomplicated device-assisted endoscopic full-thickness resection (EFTR) was performed using an anchor to center the lesion and mobilize deeper wall elements with a view to marked post-surgical fibrosis (not shown). (E) Histopathology of the SSA/P lesion with confirmed R0 resection and marked fibrosis in the deep muscle layer (*H&E*, 2.5×).

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A 50-year-old female patient with a remote history of appendectomy was referred for work-up of a large hepatic mass lesion due to right upper quadrant pain. Apart from, among other examinations, an uncomplicated percutaneous fine needle biopsy (post-hoc diagnosis of advanced intrahepatic cholangiocarcinoma referred for major liver surgery), the patient underwent upper and lower endoscopy despite having had a presumably unremarkable colonoscopy 6 months before. With an optimal cleanliness throughout the whole colon (total Boston Bowel Preparation Scale score 9), in the cecum, the appendix rest was obscured by a thick mucus layer, exhibiting a classical, though oftentimes misinterpreted as staining ''*cecal mucus sign*''[1] (Fig. 1A), unrelentingly defying water jet cleansing. To better clarify the underlying pathology intensive washing and 1% acetic acid spraying, highlighting related mucosal changes in presumed serrated sessile adenoma/polyp (SSA/P) as suggested by preliminary study data and clinical experience[2,3] (Fig. 1C). Albeit the lesion's center remained somewhat blurred by very tenacious mucus hard to be removed, the peripheral rim exhibited typical features of an SSA/P lesion, including ''*dark spots inside crypts*'' as per WASP classification (*Workgroup serrAted polypS and Polyposis*), reflective of dilated crypt openings due to related mucus production (Fig. 1D – highlighted by linked colour imaging). The patient underwent an uncomplicated device-assisted endoscopic full-thickness resection with the ancillary use of an anchor to fully center and lift the appendix rest (not shown). Albeit a transmural resection at the markedly scarred appendix rest was not achieved, final pathology of the 26×22 mm specimen with a 10×9 mm measuring flat polypoid lesion confirmed R0 resection of an SSA/P without dysplasia (Fig. 1E). Clinical follow-up at two months excluded any delayed complication.

Conflict of interest

Nothing to declare.

References

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