Filiform Polyposis: Diagnostic Challenges During Surveillance Colonoscopy

Safa Akhter, OMS-III; Rodrigo Alvarez, DO; Abdul Nadir, MD

Arizona College of Osteopathic Medicine, Midwestern University, Glendale, AZ; Gastroenterology Department, Honorhealth Four Peaks, Mesa, AZ

Introduction

- Filiform polyposis (FP), also called Giant Inflammatory Polyposis (GIP) or pseudopolyposis, is a rare clinical entity that can be seen in patients with Inflammatory Bowel Disease (IBD).
- FP/GIP is characterized as multiple finger-like projections resembling a "mass of worms". Despite being a benign inflammatory finding, FP can cause complications such as intestinal obstruction, hemorrhage, or stricture.
- Given the potential for FP to obscure neoplastic lesions, heightened awareness of the unique endoscopic challenges with FP can be essential for cancer prevention in patients with long standing IBD.

Objectives

- This case identifies the diagnostic difficulties when encountering filiform polyposis during surveillance colonoscopy in patients with Inflammatory Bowel Disease and highlights the potential role of Narrow Band Imaging in differentiating these inflammatory polyps from neoplastic polyps.

Case Description

- A 53-year-old man with a 21-year history of ulcerative colitis was evaluated for surveillance colonoscopy. He has had multiple colonoscopies over the course of his life. A prior colonoscopy in 2024 revealed adenomatous and hyperplastic polyps, as well as filiform polyps.
- The patient underwent another colonoscopy on January 2026. He reported no symptoms prior to his colonoscopy, nor on the day of.
- **Colonoscopic Evaluation and Pathology Reports**
  - Colonoscopy revealed multiple tubular adenomas (TA), hyperplastic polyps, and FP. Biopsies were obtained from the ascending, transverse, and sigmoid colon
  - Microscopic examination demonstrated:
    - One 5 mm TAs in the proximal ascending colon
    - Two 2-4 mm TAs and hyperplastic polyps in the middle ascending colon
    - Fragments of a sessile serrated polyp measuring up to 12 mm
    - Three 7-14 mm filiform polyps in the sigmoid colon
  - Narrow Band Imaging (NBI) was employed to differentiate FP from other types of polyps by examining differences in pit pattern based on the Kudo classification.
  - Histopathology of the FP demonstrated areas of lymphoid aggregates and mild hyperplastic change without evidence of malignancy.
- **Clinical course**
  - As the patient was asymptomatic, he was discharged that day and told to follow up in 1-2 years for his next surveillance colonoscopy, as per ACG guidelines for a patient with IBD.

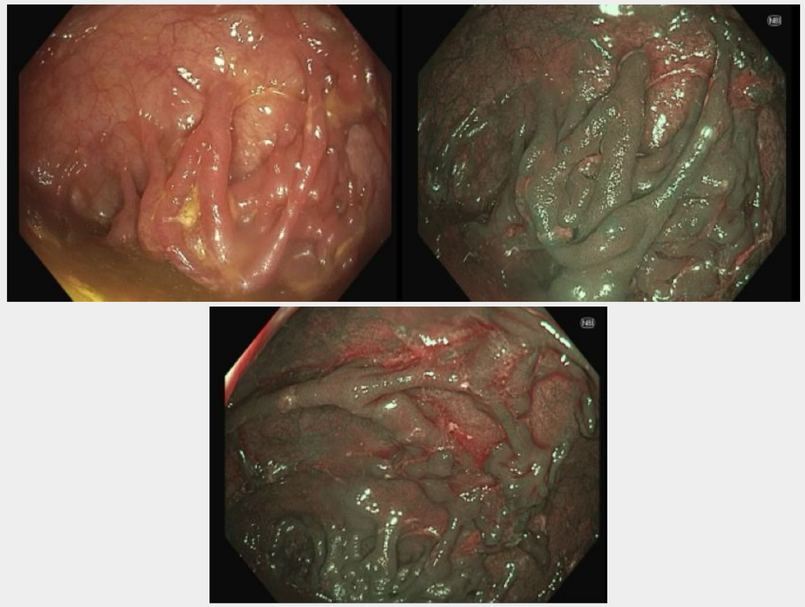

Figure 1: Filiform polyposis in the sigmoid colon. Top left: FP on standard imaging; top right: FP on NBI imaging; bottom: additional NBI view

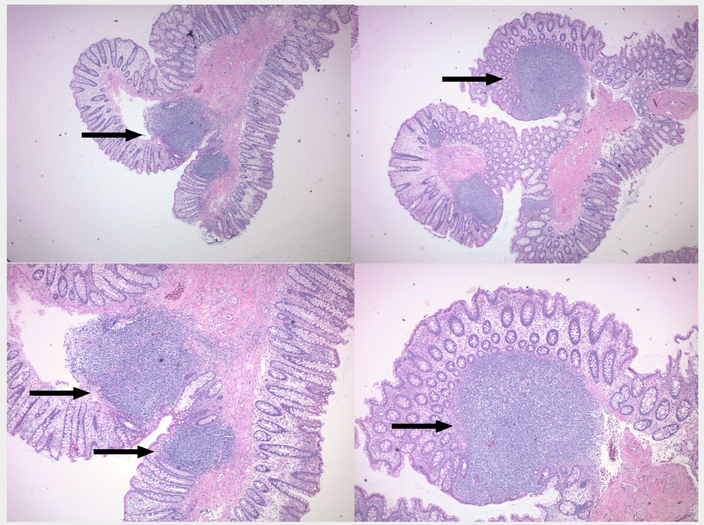

Figure 2: Histopathology of filiform polyposis in the sigmoid colon. Top row (20x): lymphoid aggregates and mild hyperplastic change. Bottom row (40x): higher magnification views highlighting the same features

Discussion

- Filiform polyps can mask dysplastic and/or malignant polyps due to their extensive and large structure. NBI is a unique imaging modality that can potentially help differentiate FP from other common polyps.
- For the collected polyps, TAs were classified as Kudo type III-L, distinguishing them from FP, which resembled Kudo classification type II.
- While NBI can be useful, it is essential to biopsy any polyp that does not typically look like FP to ensure that dysplastic or malignant polyps are not missed.

Conclusion

- This case illustrates the unique diagnostic hurdles encountered when performing colonoscopies in patients with long-standing IBD. And though advanced imaging techniques such as NBI may play a key role in differentiating FP from other polyps, FP can still mask neoplastic lesions.
- Therefore, it is essential to follow up closely with Pathologists when examining IBD patients with filiform polyposis.
- Additionally, patients with IBD are vulnerable to gaps in primary and maintenance care, making it important to ensure that they are not lost to follow up, especially if they have more challenging manifestations of disease, such as FP.
- These patients may also benefit from more frequent surveillance to ensure that dysplastic and/or malignant polyps are not missed.
- Overall, documenting and understanding these cases can shed light on their prevalence in IBD patients and improve our approach in managing similar cases.

Acknowledgements

- We'd like to thank Dr. Guo for his invaluable insight and guidance throughout this project. His expertise was essential for bringing this case report together.

References

- Bragg JD. Osteopathic primary care of patients with inflammatory bowel disease: a review. *J Osteopath Assoc.* 2014;114(9):695-701. doi:10.7556/jaoa.2014.139
- Brozna JP, Fisher RL, Barwick KW. Filiform polyposis: an unusual complication of inflammatory bowel disease. *J Clin Gastroenterol.* 1985;7(5):451-458. doi:10.1097/00004836-198510000-00019
- Naymagon S, Mikulasovich M, Gui X, Ullman TA, Harpaz N. Crohn's-like clinical and pathological manifestations of giant inflammatory polyposis in IBD: a potential diagnostic pitfall. *J Crohn's Colitis.* 2014;8(7); 635-640. doi:10.1016/j.crohns.2013.11.027
- Sheikholeslami MR, Schaefer, RF, Mukunyadzi P. Diffuse giant inflammatory polyposis: a challenging clinicopathologic diagnosis. *Arc Pathol Lab Med.* 2004;128(11):1286-1288. doi:10.5858/2004-128-1286-DGIPAC