Scottish Society of Gastroenterology SSG

WINTER MEETING 2019

Abstract Submission Form

TITLE	**Colonic Malakoplakia Mimicking Colorectal Malignancy in a Renal Transplant Patient**
AUTHOR(S)	Emma MacGregor[1], Dr Kirsty Slaven[2], Dr Sioban Fraser[2], Dr John Paul Seenan[2]
ADDRESS	[1]Trinity College, Dublin, Ireland [2]Queen Elizabeth University Hospital, 1345 Govan Road, G51 4TF, Scotland
ABSTRACT DETAILS:	
Case Presentation:	A 62 year old male receiving Mycophenolate Mofentil and Tacrolimus for previous cadaveric renal transplant attended for colonoscopy after urgent GP referral. He had 4 week history of intermittent rectal bleeding with borderline qFIT of 12ug/g. Colonoscopy revealed a large, 5cm ulcerated and partly villous caecal lesion adjacent to the appendiceal orifice. Multiple biopsies were taken and urgent Contrast-enhanced computerised tomography (CT) advised. This revealed inflammatory stranding and prominent mesenteric nodes surrounding the right colon with hyper enhancement of irregularly ulcerated mucosal surface within the caecum. As the endoscopic and radiological appearances were suggestive of malignancy the case was referred urgently to the colorectal cancer multidisciplinary team (MDT) meeting. Histology revealed appearances consistent with colonic malakoplakia, characterised by small grey concretions which were positive for von Kossa stains. Following discussion with his Renal team, the patient's immunosuppressive regime was reduced.
Discussion:	Malakoplakia is a rare inflammatory condition characterised by large granular histiocytes known as von Hansemann cells which contain distinctive intracytoplasmic inclusions known as Michaelis-Guttman (MG) bodies[1,2]. Malakoplakia can affect many organ systems, but the predominant site of involvement is the genitourinary (GU) tract. Gastrointestinal (GI) tract and particularly caecal involvement has occasionally been described[4]. Cases occur in the immunosuppressed, typically solid-organ transplant recipients where GU involvement is often associated with recurrent *E.coli* urinary infections. Suggested treatment options include reduction in immunosuppression and antibiotic therapy with surgical resection reserved for complications or when the suspicion of underlying malignancy remains high[3,4]. The development of colonic malakoplakia may be insidious with diagnosis often as an incidental finding or following complication (e.g. perforation) when prognosis may be poor due to comorbidity and underlying immunosuppression. Only 7 cases of extra-renal sites of malakoplakia following renal transplantation have been reported in the literature so far, with six patients experiencing significant morbidity[4]. We describe a further example of colonic malakoplakia following renal transplantation.
Conclusions:	Colonic Malakoplakia is a rare finding which may mimic colorectal malignancy. It should be considered in immunosuppressed patients presenting with lower gastrointestinal symptoms and/or colonic lesions especially following renal transplantation.
References:	1. McClure J. Malakoplakia of the gastrointestinal tract. Postgrad Med J. 1981;57:95–103. 2. Lewin KJ, Fair WR, Steigbigel RT, Winberg CD, Droller MJ. Clinical and laboratory studies into the pathogenesis of malacoplakia. J Clin Path. 1976;29:354–63. 3. Berney T, Chautems R, Berney T, Chautems R, Ciccarelli O, Squifflet JR, Latinne D, Pirson Y. Malakoplakia of the caecum in a kidney-transplant recipient: presentation as acute tumoral perforation and fatal outcome. Transplant international. 1999 Jul;12(4):293-6. 4. Mitchell, A., & Dugas, A. Malakoplakia of the colon following renal transplantation in a 73 year old woman: report of a case presenting as intestinal perforation. *Diagnostic pathology*, 2019;*14*(1), 22. doi:10.1186/s13000-019-0799-z