

A Rare Mimicker of Malignancy: Inflammatory Cloacogenic Polyp Presenting as Obstruction in a Colon Cancer Survivor

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Abstract: Inflammatory cloacogenic polyps are rare and often discovered either during routine colorectal cancer screenings or in symptomatic patients presenting with hematochezia. In unusual cases, they can present as an adhesive obstruction with radiological and clinical findings suggestive of a suspicious recurrent colorectal malignancy lesion. Because these polyps can mimic cancer during endoscopy, a detailed tissue examination is crucial for making the correct diagnosis and planning treatment. In this report, we share a challenging case where a patient with a history of cancer presented with signs that strongly suggested a malignant recurrence, but the final diagnosis was an inflammatory cloacogenic polyp. This case highlights the critical role of regular endoscopic monitoring in managing such complex conditions.

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Introduction

The inflammatory cloacogenic polyp (ICP) was first introduced in 1981 (Lobert and Appelman, 1981). It is a benign polyp that arises from the anal transitional zone and rectum (Prakash et al., 2022). It has distinct histological and clinical features, setting the foundation for understanding their pathogenesis and relationship to various anorectal and gastrointestinal disorders (Chiam et al., 2023). This condition is rare and usually detected during screening for colorectal cancer or in symptomatic patients presenting with lower gastrointestinal symptoms. It is unusual to diagnose this condition on any patient suspected to have recurrent colorectal cancer. Imaging, endoscopic and histological diagnosis are warranted prior to declaring this diagnosis. We experienced a 60-year-old woman, initially suspected of having a recurrence of colon cancer based on clinical presentation, imaging, and endoscopic findings, was diagnosed with an ICP, hence we discussed our treatment modalities.

Case report

A 60-year-old woman with a history of left hemicolectomy, cholecystectomy, and appendectomy for sigmoid colon cancer (well-differentiated adenocarcinoma, treated in 2005) presented with two days of colicky abdominal pain, frequent vomiting (over 10 episodes a day), and diarrhoea. She was alert and her vital signs were stable. On examination, there was tenderness in the lower abdomen and umbilical region. A rectal exam revealed an irregular mass at the 6 o'clock position. An abdominal radiograph showed dilated bowel loops with a "stacked coins" appearance, indicating bowel obstruction. Biochemical

tests and tumour markers were unremarkable.

A contrast-enhanced computed tomography scan of the abdomen and pelvis showed a dilated segment of the jejunum in the mid-abdomen without a clear transition point. It also revealed an enhancing lesion near the posterior wall of the rectum (Figure 1), located 6.4 cm from the anal verge and measuring 1.0×1.3 cm, with nearby mesorectal and presacral lymph nodes. Diverticulosis in the ascending colon and a small amount of free fluid in the abdomen were also noted.

Following successful conservative management of adhesive obstruction, a colonoscopy was performed. This revealed a suspicious polyp, 1.5 cm in size with a short stalk, located 8 cm from the anal verge as shown in Figure 2. The polyp was successfully removed via snare polypectomy without any complication. Multiple diverticula were observed in the transverse colon, along with a benign appearing 1 cm polyp in the proximal transverse colon. Histopathological examination (HPE) confirmed it as a mid-rectal ICP (Figure 3). A follow-up colonoscopy six months later showed a new rectal lesion 6 cm from the anal verge. The area had thickened, granular mucosa, and a small, firm 5 mm lesion likely related to the previous polypectomy. Biopsy results showed a benign mucosal ulcer with hyperplastic changes. The patient remains under our regular follow-up, with tumour markers checked every six months and a repeat colonoscopy planned in a year.

Discussion

ICPs are rare growths that develop mainly in the anorectal region and are thought to be part of the mucosal prolapse syndrome (Chiam et al., 2023).

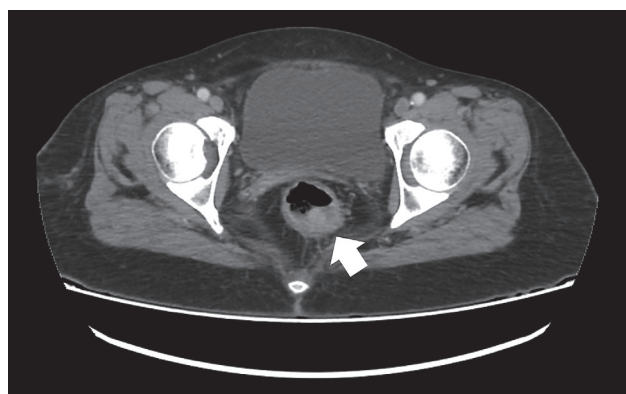


Figure 1: A contrast-enhanced abdominal and pelvic computed tomography scan demonstrated a distended jejunal segment in the mid-abdomen in the absence of a clear transition point. The study also revealed a 1.0×1.3 cm enhancing lesion (white arrow) involving the posterior rectal wall at mid-rectum.

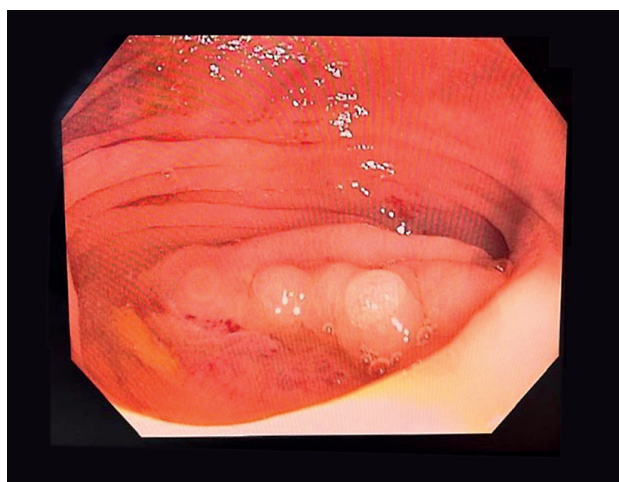


Figure 2: A colonoscopic view of a suspicious polyp, 1.5 cm in size with a short stalk, located 8 cm from the anal verge.

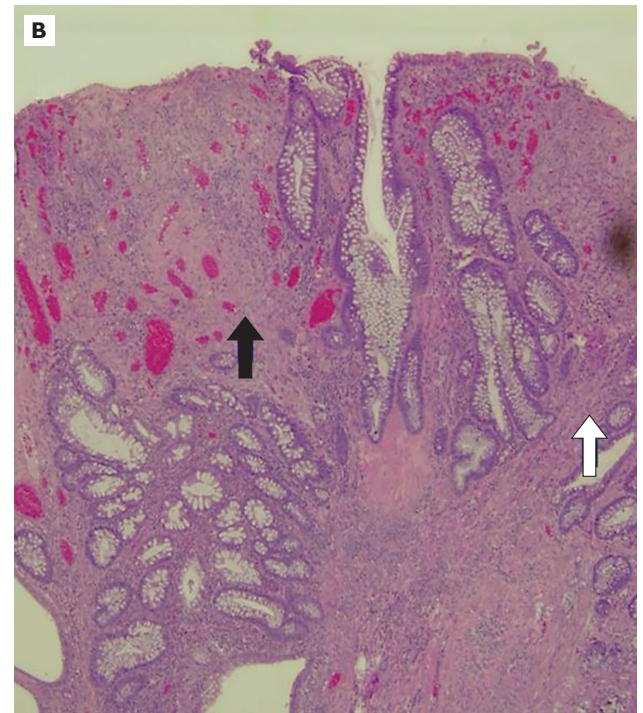
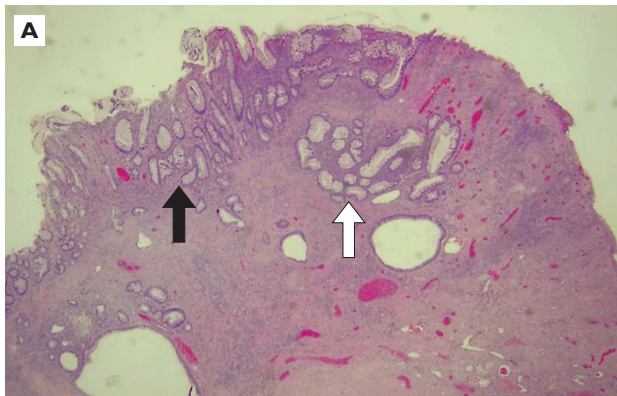


Figure 3: (A) The benign crypts have tubulovillous architecture with elongated crypts stretching into the submucosa (black arrow). Some of the crypts are arranged in lobular architecture (white arrow) (haematoxylin and eosin, 10× magnification). (B) Thickened muscularis mucosa with extension into the lamina propria with some mucosal prolapse features (muscularis mucosae with splayed fibers) are seen (white arrow). Reactive swollen endothelial cells and fibroblasts with mixed acute and chronic inflammatory cells are seen (black arrow) (haematoxylin and eosin, 20× magnification). Cytomegalovirus immunohistochemistry stain is negative.

They share similar features with other benign anorectal conditions like solitary rectal ulcers and prolapsing polyps, likely arising from repeated mucosal injury and healing due to abnormal rectal contractions. Despite their distinct appearance, the exact cause of ICP remains unclear because of limited research (Monreal-Robles et al., 2019; Prakash et al., 2022). In this case, a patient with a history of colorectal cancer presented with a suspicious rectal polyp and nearby lymph node seen on imaging, raising concern for a possible new cancer. Urgent colonoscopy was performed, but the presence of anal intraepithelial neoplasia within an ICP made diagnosis and management more challenging (Hanson and Armstrong, 1999).

Although only a few cases have linked ICP to cancer (as outlined in Table 1), research has highlighted their potential to progress from benign to malignant. Advanced endoscopic techniques, such as high-definition colonoscopy with narrow-band imaging, have helped differentiate polyps with suspicious features, as shown in studies by Lambin et al. (2022) and Reissnerová et al. (2022), though histology often confirms benign ICPs. In contrast, magnetic resonance imaging findings by Ferrer Martínez et al. (2026) initially suggested malignancy, but histology again revealed a benign polyp. In our patient, imaging showed a suspicious rectal polyp with nearby lymph nodes, raising concern for cancer recurrence. While classification systems like the Japan NBI Expert Team via narrow-band imaging magnification could aid diagnosis, our center lacks the resources for such detailed endoscopic evaluations, making

histopathology essential (Lobert and Appelman, 1981). The biopsy showed characteristic features of ICPs, including irregular crypts, submucosal involvement, and chronic inflammation.

ICPs typically show a tubulovillous structure with benign crypts that may extend into the submucosa and sometimes appear in a lobular pattern. The muscularis mucosa is often thickened and extends into the lamina propria, with signs of mucosal prolapse such as splayed muscle fibers. The supporting tissue contains swollen endothelial cells, fibroblasts, and a mix of acute and chronic inflammatory cells. Other common features include surface erosion, glandular overgrowth, and fibromuscular tissue expansion. Recognizing these features is important to distinguish ICPs from other anorectal conditions (Marcos et al., 2019). Due to the risk of recurrence or possible malignant transformation, careful endoscopic follow-up after removal is essential (Özgenel et al., 2016).

Rectal bleeding and changes in bowel habits are common symptoms of ICPs, though up to 20% of cases may be asymptomatic. These polyps are typically found in the anorectal area and rarely cause adhesive intestinal obstruction, as shown in Table 1. What makes this case unusual is that the patient had a history of sigmoid adenocarcinoma over a decade ago, with no signs of recurrence during the past three years of surveillance colonoscopies. Now, they present with bowel obstruction and a palpable rectal mass on examination, requiring inpatient colonoscopy after conservative treatment. This combination of factors makes it a rare and unique presentation of ICP.

ICPs usually measure between 1 to 5 cm and are mostly sessile, though they can sometimes have a stalk. They may appear alone or in clusters and can exist alongside other types of benign polyps, like hyperplastic or adenomatous ones. It can be difficult

to distinguish ICPs from potentially cancerous lesions during colonoscopy, especially when they are large or have a bleeding surface. In our case, the patient had a sessile polyp that looked highly suspicious for cancer. However, biopsy results showed it was an ICP.

Table 1: Cases related to ICP which were published since 2016 until now

Case (Year)	Age	Presenting symptom	Clinical finding	Diagnosis	Management	Surveillance scope
Ferrer Martínez et al. (2026)	25	6/12 tenesmus, anemia and weight loss	Painful rectal mass 6 cm from anal margin. MRI finding of T1-2, no lymph node involvement	Suspicious rectal lesion to rule out malignancy	Transanal endoscopic	
Reissnerová et al. (2022)	14	6/12 intermittent rectal bleeding	Palpable polypoidal lesion at 1 cm from dentate line Scope finding of cauliflower-like mass	Suspicious rectal lesion HPE: lamina muscularis mucosae is hyperplastic (bold arrow) with proliferation of smooth muscle outstretching to lamina propria mucosae. Glandular hyperplasia, tubulovillous architecture (thin arrow)	Transanal endoscopic microsurgery (TEM) Followed by sufficient fibre and optimal fluid intake	Whitish base after polyp removal
Prakash et al. (2022)	53/F	History of low-grade papillary tumour of the bladder, cigarette smoking, and alcohol abuse. Asymptomatic. For colorectal cancer screening	Digital rectal examination shows dark colour stool and positive immunochemical faecal occult blood test. Colonoscopy show 2 sessile polyps 7 mm in the rectum (HPE: prolapsed induced inflammatory cloacogenic polyp), 7 polyps (15–25 mm) in the sigmoid (HPE: tubular adenoma and serrated adenoma)	Benign feature sessile polyp of rectum with multiple sigmoid polyp with benign feature	Snare polypectomy	Endoscopic surveillance
Lambin et al. (2022)	38/F 71/F	Abdominal pain, hematochezia, and mucus in the stool. Hematochezia	1. Pedunculated inflammatory lesion with 20 mm head and some area of irregular pit pattern (Kudo Vn) on narrow-band imaging 2.30 mm red head in sigmoid colon. Dilatation of lymphatic vessels on the stalk of polyp	Both cases showing malignant feature appearances in which in favours of malignancy	1. En bloc resection with a hot snare 2. Endoscopic submucosal dissection with the tip of snare allowed en bloc resection Both HPE finding of ulcerated surface with dilated colonic glands within inflammatory stroma and significant hemorrhagic suffusion. The glands were dilated, sometimes cystic and filled with mucopurulent material. Mucosa adjacent to stalk was normal. No sign of malignancy or dysplasia	Endoscopic surveillance

Case (Year)	Age	Presenting symptom	Clinical finding	Diagnosis	Management	Surveillance scope
Ochiai et al. (2021)	45/M	Strong family history of malignancy with previous history of colonoscopy which showed multiple polyps, which were consistent with ICPs on the dentate line. Presented with hematochezia	Colonoscopy at presentation revealed multiple polyps in the lower rectum as before, two of which had grown in size, and the shapes of the top were different from surrounding polyps	Biopsies at lower rectum were performed and the pathological diagnoses were adenocarcinomas for both lesions	Endoscopic submucosal dissection (ESD) was performed and the two lesions were diagnosed as double well-differentiated adenocarcinomas arising from ICPs	Follow-up colonoscopy performed 10 months after ESD showed no recurrence in the rectum
Marcos et al. (2019)	67/F	Chronic constipation with intermittent hematochezia and iron deficiency anaemia	DRE show soft mobile mass at lower rectum. Colonoscopy showed numerous, confluent, light yellowish, sessile polyps at anorectal junction, in biopsy taken	HPE of biopsies showed surface erosion with reactive inflammatory and reparative changes covered by a fibrinopurulent cap and granulation tissue, glandular hyperplasia, and a lamina propria, in part, replaced by an overgrowth of fibromuscular tissue	Planned for endoscopic resection. However, didn't make it as died because of cardiovascular event	
Özgenel et al. (2016)	24/M	Hematochezia for 1/12	Colonoscopy showed 1.5 cm polyp at rectum, biopsied	HPE show findings with ulcers, minimal architectural distortion, hyperplastic changes and regenerative atypia, fibromuscular hyperplasia in the lamina propria, and vessel-rich colonic polypoid tissues	Endoscopic polypectomy	

ICP – inflammatory cloacogenic polyp; MRI – magnetic resonance imaging; HPE – histopathological examination; F – female; M – male

This raised concerns about whether the endoscopic removal was complete and had clear margins. A follow-up colonoscopy later confirmed that the site was now a benign mucosal ulcer with hyperplastic changes, ruling out malignancy and providing reassurance.

The treatment approach for colonic polyps largely depends on endoscopic evaluation, with the choice between simple snare polypectomy and advanced resection guided by the polyp's malignant potential and the endoscopist's skill (Özgenel et al., 2016). ICPs, though rare and typically benign, require careful assessment of features like size, location, and stalk presence to determine the best removal method. Sessile polyps can be more challenging and often require experienced handling, including submucosal injection before removal to reduce the risk of deep

tissue injury. Unlike standard surveillance for adenomas, there's no clear guideline for follow-up colonoscopies in ICP cases. Some suggest checking as early as 6 weeks after resection, but in our practice, we opt for a 6-month interval due to limited understanding of ICP growth patterns. Because the risk of cancer is low, managing ICPs and related colonoscopy complications calls for an individualized, risk-based approach rather than a one-size-fits-all protocol.

Conclusion

ICPs are rare, benign anorectal lesions that can mimic cancer, especially in patients with a history of colorectal malignancy. Our case involved an unusual presentation with adhesive obstruction and a suspicious rectal mass,

raising concern for recurrence. Despite concerning findings, histopathology confirmed a benign ICP, highlighting the importance of tissue diagnosis. With no standard surveillance guidelines, follow-up should be individualized based on risk factors and lesion features. Regular monitoring remains important due to the low but possible risk of recurrence or malignancy.

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References

- Chiam, K. H., Yong, S. M., Tan, C. C., Halim, R. A., Muthukaruppan, R. (2023) Complementary diagnostic and therapeutic approach of a rare inflammatory cloacogenic polyp – A case report. *Dig. Med. Res.* **6**, 11.
- Ferrer Martínez, A., Valle Rubio, A., Manuel Vázquez, A., Ramos Rodríguez, J. L. (2026) Inflammatory cloacogenic polyp: Differential diagnose with endoscopic malignant lesions. *Rev. Esp. Enferm. Dig.* **118(8)**, 475–476.
- Hanson, I. M., Armstrong, G. R. (1999) Anal intraepithelial neoplasia in an inflammatory cloacogenic polyp. *J. Clin. Pathol.* **52(5)**, 393–394.
- Lambin, T., Lavrut, P. M., Lafeuille, P., Rivory, J., Rostain, F., Bonniaud, P., Pioche, M. (2022) Cloacogenic polyp: A rare type of polyp. *Endoscopy* **54(3)**, E117–E118.
- Lobert, P. F., Appelman, H. D. (1981) Inflammatory cloacogenic polyp. A unique inflammatory lesion of the anal transitional zone. *Am. J. Surg. Pathol.* **5(8)**, 761–766.
- Marcos, P., Eliseu, L., Cunha, M. F., Vasconcelos, H. (2019) Cloacogenic polyps. *ACG Case Rep. J.* **6(5)**, e00083.
- Monreal-Robles, R., González-González, J. A., Benavides-Salgado, D. E., Maldonado-Garza, H. J. (2019) Prolapsing mucosal polyp: A form of colonic polyp not to be forgotten. *Rev. Gastroenterol. Mex. (Engl. Ed.)* **84(3)**, 407–409.
- Ochiai, Y., Matsui, A., Ito, S., Takazawa, Y., Kikuchi, D., Hoteya, S. (2021) Double early rectal cancer arising from multiple inflammatory cloacogenic polyps resected by endoscopic submucosal dissection. *Intern. Med.* **60(4)**, 533–537.
- Özgenel, Ş. M., Temel, T., Yılmaz, E., Tokmak, S., Özakıyol, A. (2016) Inflammatory cloacogenic polyp: A rare kind of benign polyp to be cured with endoscopic and/or surgical removal. *J. Coloproctol.* **36(3)**, 176–178.
- Prakash, N., Vyas, S. J., Mohammed, A., Waghay, N. (2022) Inflammatory cloacogenic polyp: A rare benign colorectal polyp. *Cureus* **14(2)**, e22014.
- Reissnerová, M., Starý, D., Plánka, L., Frola, L., Kunovský, L., Jabandžiev, P. (2022) Inflammatory cloacogenic polyp in an adolescent – Case report and review of the literature. *Rozhl. Chir.* **101(10)**, 499–503.