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Letter to the Editor

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Squamous Cell Carcinoma of the Pouch

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To the Editors,

We report a squamous cell carcinoma (SCC) of the pouch in a patient with a longstanding history of untreated pouchitis. A 39-year-old patient underwent total coloproctectomy with ileal J-shaped reservoir and ileo-anal anastomosis for uncontrolled ulcerative colitis. The histological specimen was free of dysplasia. The patient was lost to follow-up for 26 years until he was diagnosed with pouchitis and treated successively with antibiotics and biologics. Endoscopies repeatedly identified superficial pouch erosions, and biopsies were systematically consistent with chronic inflammation. In 2020, a routine endoscopy revealed a three-fourths circumferential ulcerated lesion of the pouch, extending over 10 cm, with an intact anal canal (Figure 1). A well-differentiated SCC (HPV negative) was diagnosed. Computed tomography, pelvic magnetic resonance imaging, positron emission tomography scan, and lower endoscopic ultrasound did not identify any distant lesion. Neoadjuvant radiochemotherapy (Capecitabine) followed by surgical ablation of the reservoir was decided. Eight weeks after radiotherapy, a resection of the ileal reservoir with a large pelvis lymph node dissection and a terminal Brooke's ileostomy was conducted. Histology confirmed the SCC with 3 positive lymph nodes in the residual mesorectum (ypT4N1b). The pelvic lymph node dissections did not reveal any metastasis, although a tumoral implant was identified along the left internal iliac artery. Surgical re-exploration for refection was performed at day 42 after surgery owing to a persistent ureteral leak and identified peritoneal SCC carcinomatosis. The patient died soon after.

Ileal pouch cancer is a rare complication after total coloproctectomy in IBD with a cumulative incidence at 5, 15, and 25 years of 0.2%, 0.8%, and 3.4%, respectively.[1] The cancer (mostly adenocarcinoma) usually initiates at the rectal cuff or at the anal transitional zone and exceptionally within the pouch itself. Expert recommendations suggest that close (yearly) surveillance must be offered to patients with risk factors: previous dysplasia/colorectal cancer (CRC), family history of CRC, long rectal cuff, and concomitant primary sclerosing cholangitis (PSC).[2] Pouch radiotherapy alone is contraindicated by most authors due to the devastating effect on pouch functionality.[3] In a systematic review,[4] we found 2 fatal cases of pouch SCC, both with an extensive neoplasia on diagnosis. The first patient (41 years old) received neoadjuvant radiochemotherapy and surgery; the second patient (70 years old) had surgery alone. Although the thera-

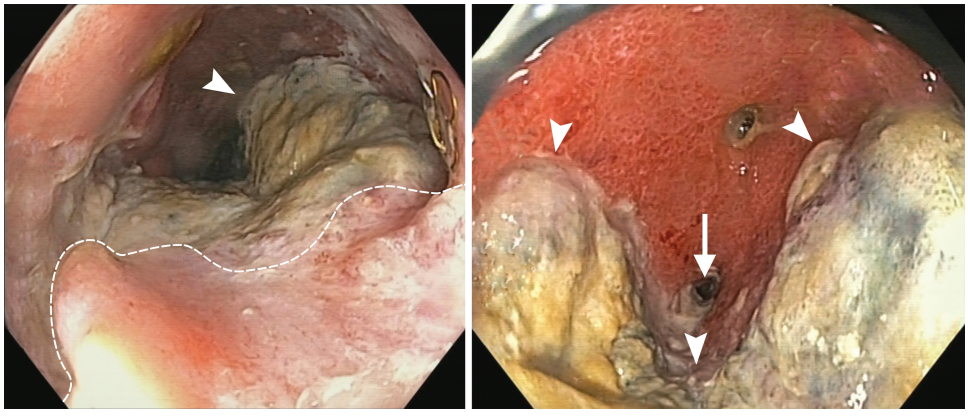

Figure 1. Squamous cell carcinoma (arrowheads) of the pouch in a 74-year-old UC patient with a longstanding history of pouchitis. The anal canal is below the dotted white line. The arrow indicates the ileum.

peutic strategy of anal SCC is well defined, the management and pathogenesis of pouch SCC is unclear. One hypothesis is that squamous metaplasia due to chronic mucosal inflammation undergoes malignant change.[5] This report questions the endoscopic/histologic surveillance in patients with chronic pouchitis regardless of risk factors. The benefits and risks of such complex excisional procedures is questionable.

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Author Contributions

A.D., J.L., J.F.R.: collection of data and writing of the manuscript. All authors approved the final version of the manuscript.

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Conflicts of Interest

None.

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