Pneumatosis cystoides intestinalis (PCI), that is, presence of gas within the colonic wall, often has a polypoid appearance and can thus cause diagnostic uncertainty for the endoscopist [1–3].

**Case 1.** A 51-year-old man underwent colonoscopy for diarrhoea and slight haematochesia. Colonoscopy revealed small, sessile, ball-shaped polyps, which were clustered in streaks and covered with normal mucosa in the hepatic flexure region (Fig. 1). The polyps disappeared on puncturing and suction with a needle (Video 1). The patient was symptom-free at that time and no pathology was found on an abdominal plain X-ray film. (This case has been reported previously [4].)

**Case 2.** A 60-year-old obese man with a history of *Clostridium difficile* colitis was referred for lower endoscopy for a suspected perianal fistula. The patient was otherwise asymptomatic. Several small, sessile polyps were seen clustering in the splenic flexure region. Some of them were covered with swollen and reddish but otherwise normal mucosa (Fig. 2). An abdominal plain X-ray was normal; stool samples were negative for both standard culture and for *C. difficile* toxins A and B. The aspirated material was sent for cytological examination. Numerous foreign body multinucleated giant cells on a background of normal mucosal epithelial cells were found in both cases (Fig. 3 and 4). To our knowledge these are the first two cases of diagnosis of PCI by fine needle aspiration cytology.

We conclude that a diagnosis of PCI suspected on endoscopy can be effectively confirmed by puncturing the pseudocysts and cytological examination of the aspirated material. Collapse of the pseudocysts on puncture and the presence of giant multinucleated cells in the cytological examination are sufficient for the final diagnosis.
cal smears are supposed to be pathogno-
monic for this condition. The diagnosis
can thus be easily confirmed and unne-
cessary treatment avoided.

Acknowledgement

This study was supported by research
project MZO 00179 906 from the Ministry
of Health of the Czech Republic.

References

1 Heng Y, Schuffler MD, Haggitt RC et al. Pneu-
matomosis intestinalis: a review. Am J Gastro-
enterol 1995; 90: 1747 – 1758
2 Goldberg E, LaMont JT. Pneumatosis intesti-
nalis. UpToDate [serial online] 2008 16.3.
Available from http://www.uptodate.com
Accessed: 12 November 2008
3 Höer J, Truong S, Vírnich N et al. Pneumatosis
cystoides intestinalis: confirmation of diag-
nosis by endoscopic puncture. A review of
pathogenesis, associated disease and ther-
apy and a new theory of cyst formation. En-
doscopy 1998; 30: 783 – 799
4 Ryška A, Hornychová H, Tyčová V et al. Pneu-
matomosis cystoides intestinalis – is it possi-
ble to diagnose it by fine-needle aspiration
cytology? Diagn Cytopathol 2006; 34:
793 – 795

J. Cyrany1, M. Kopáčková1, S. Rejchrt1,
H. Hornychová2, M. Tomšová2,
V. Tyčová2, A. Ryška2, J. Bureš1
1 2nd Department of Internal Medicine,
Charles University in Prague, Faculty of
Medicine and Teaching Hospital, Hradec
Králové, Czech Republic
2 The Fingerland Department of Patholo-
y, Charles University in Prague, Faculty
of Medicine and Teaching Hospital,
Hradec Králové, Czech Republic

Corresponding author
J. Cyrany, MD
2nd Department of Internal Medicine
Charles University Teaching Hospital
Sokolská 581
500 05 Hradec Králové
Czech Republic
Fax: +420-495-834785
jiri.cyrany@email.cz