Salivary gland choristoma in large bowel

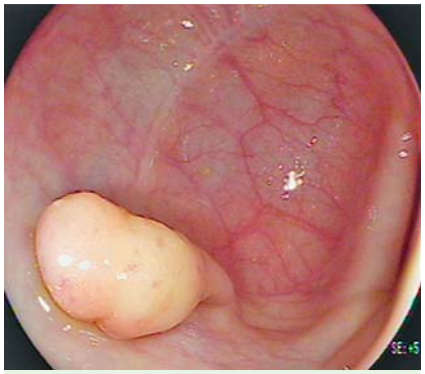


Fig. 1 Endoscopic image of pedunculated yellowish polypoid lesion.

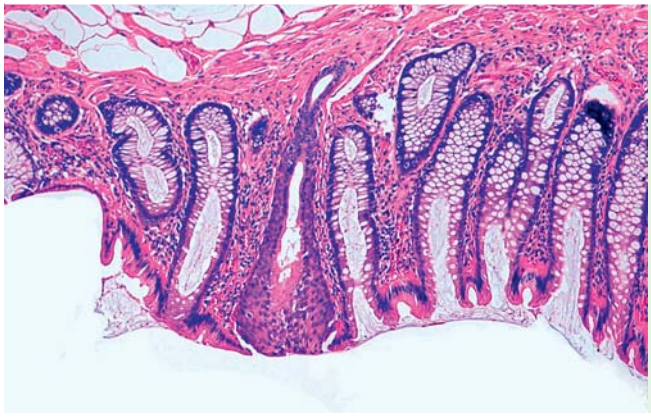
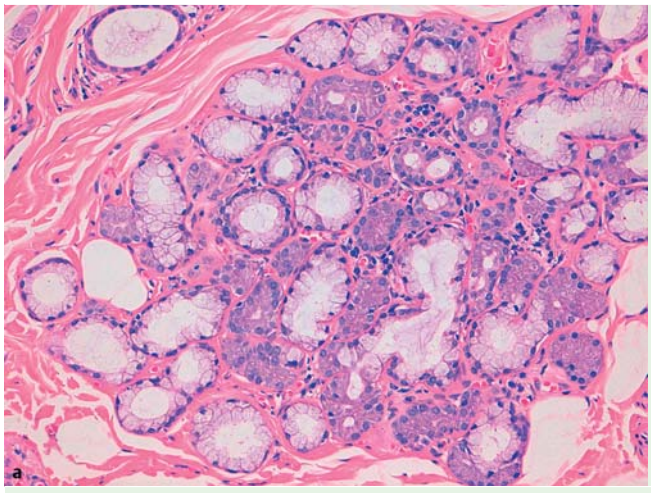


Fig. 2 Intercalated duct connected with the mucosal surface (hematoxylin and eosin; original magnification ×10).



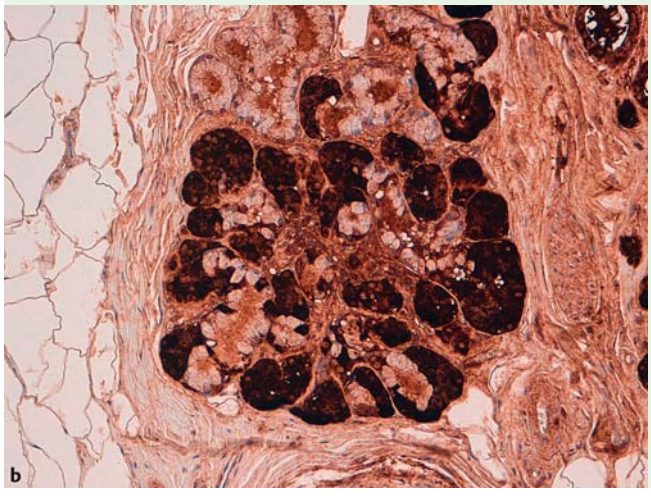


Fig. 3 Mixed acini with mucous cells near the intercalated duct and serous Giannuzzi crescents at the bottom of the acini, and only serous acini: **a** hematoxylin and eosin (original magnification ×20); **b** lysozyme stain (original magnification ×20).

The occurrence of heterotopic tissue in the large bowel is relatively rare. The most common type of tissue in such heterotopia is gastric mucosa, but rare cases of pancreatic and salivary tissue are also reported in literature. All cases of salivary choristomas reported in literature arose in the rectum–anal canal region [1 – 5].

Here we report a submucosal salivary gland choristoma in the sigma of a 55-year-old woman who underwent large-bowel endoscopy for colorectal carcinoma screening.

At gross examination of the bowel we found a pedunculated polypoid lesion of 1 cm situated at 19 cm from the anal verge, resembling a submucosal lipoma without other mucosal alterations (▶ **Fig. 1**).

At histological examination we found a small aggregate of acinar glands with mixed mucous–serous features in the submucosa. In addition, we found an intercalated duct composed of a double layer of cells – epithelial and myoepithelial – that reached the mucosal surface (▶ **Fig. 2**). Immunohistochemical staining was performed in order to confirm the nature of the lesion. The glands were positive for lysozyme antibody and negative for pancreatic amylase, S-100 protein, chromogranin, and synaptophysin. The morphology of the glands and the immunostaining were consistent with the typical architecture of normal mixed salivary glands (▶ **Fig. 3**).

Only four other cases of salivary gland heterotopia in the large bowel have previously been reported in the literature; all were a histologically mixed type, all arose in the rectum–anal canal mucosa, and they were most prevalent in men. Two cases also showed gastric heterotopia, something that we have not found in the case reported here.

Some authors explained the presence of heterotopic salivary gland tissue in the large bowel as anomalous differentiation of embryonic remnants or as metaplastic changes [1 – 3]. We think that the absence of other anatomic structures in the sigma,

such as perianal glands, in which metaplastic changes can occur, suggests that the mixed salivary glands we found are true choristomas.

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Competing interests: None

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