

A 27-year-old woman underwent colonoscopy because of chronic constipation and a family history of colon cancer. Colonoscopy revealed a 1.2-cm yellowish sessile lesion with transparent overlying mucosa, at the descending colon (Figure 1 a). The mass was firm in consistency. After a mucosal defect was created using a biopsy forceps, a yellowish mass was extruded that spontaneously separated into two fragments (Figure 1 b). Endoscopic mucosal resection was done to remove residual mucosa.

Histopathologic examination of the mass revealed a well-demarcated plant skin surrounding multiple calcified cellular structures (Figure 2 a). The possibility of it being a plant seed was considered. A fibrotic area, suspected to be a previous mucosal defect was found on the resected mucosa (arrow, Figure 2 b). Finally, a stercolith embedded in the colon wall was diagnosed.

An intramural foreign body in the digestive tract is an unusual condition. A sharp foreign body easily damages the mucosa, increasing the likelihood of its becoming intramural. There are case reports of intramural foreign bodies in the esophagus [1], but this is the first report of a stercolith embedded in the wall of the colon. Removal of a submucosal tumor using a biopsy forceps has been reported [2], and we used the same method to successfully remove this intramucosal stercolith. In this case, we demonstrated not only the intramucosal location but also the mucosal defect where the foreign body might have entered.

Endoscopy\_UCTN\_Code\_CCL\_1AD\_2AC  
Endoscopy\_UCTN\_Code\_CCL\_1AD\_2AH

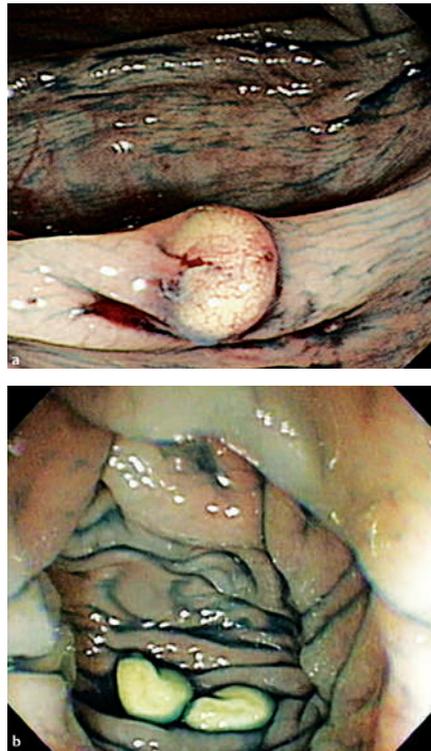


Figure 1 a Colonoscopy revealed a 1.2-cm yellowish sessile lesion with transparent overlying mucosa at the descending colon. b After a mucosal defect was created using a biopsy forceps, a yellowish mass was extruded that spontaneously separated into two fragments.

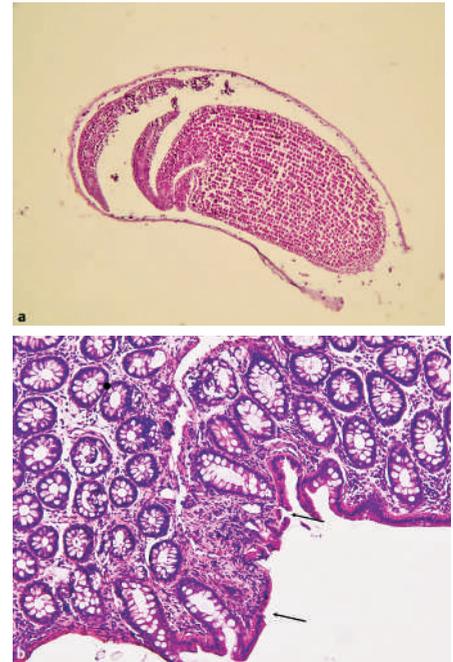


Figure 2 a Histopathologic examination of the mass revealed a well-demarcated plant skin surrounding multiple calcified cellular structures (hematoxylin and eosin [H&E]; original magnification  $\times 40$ ). b A fibrotic area, suspected to be a previous mucosal defect, was found on the resected mucosa (arrow) (H&E; original magnification  $\times 100$ ).

C.-M. Tai<sup>1</sup>, K.-J. Lin<sup>2</sup>, C.-T. Lee<sup>1</sup>, C.-H. Tu<sup>1</sup>,  
D.-S. Perng<sup>1</sup>, H.-P. Wang<sup>3</sup>

<sup>1</sup> Department of Internal Medicine, E-Da Hospital, I-Shou University, Kaohsiung, Taiwan

<sup>2</sup> Department of Pathology, E-Da Hospital, I-Shou University, Kaohsiung, Taiwan

<sup>3</sup> Departments of Emergency Medicine, National Taiwan University Hospital, and College of Medicine, National Taiwan University, Taipei, Taiwan.

## Corresponding author

H.-P. Wang, MD

Department of Emergency Medicine, National Taiwan University Hospital and National Taiwan University College of Medicine

7 Chung-Shan South Road  
Taipei 100, Taiwan

Fax: +886-2-23223150

Email: whp@ha.mc.ntu.edu.tw

## References

- Mathur NN, Kumar S, Bothra R. Intramural foreign body in oesophagus. *Int J Pediatr Otorhinolaryngol.* 2004; 68: 837–839
- Mah YH, Huang SP, Chen JH et al. Gastric submucosal tumor removal. *Gastrointest Endosc* 2005; 61: 290–291