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A rectocolic hemangioma as the cause of rectal bleeding and treated with rubber-band ligation and sclerotherapy

We read with great interest the article by Zurakowski et al. [1] about the treatment of cavernous hemangiomas.

We also had a difficult case in a 19-year-old female with recurrent painless rectal bleeding and iron-deficiency anemia. She had been admitted eight times with the same symptoms since the age of 5 years. When she was 9 years old, she was admitted to the intensive care unit due to anemia of 2.6 g/dL following recurrent rectal bleeding.

During the course of her hospitalizations, she underwent several complementary exams: the electrophoresis of hemoglobins and proteins were normal; the abdominal and pelvic ultrasounds with Doppler were normal, as was the upper endoscopy; the scintigraphy to search for Meckel's diverticulum was negative. She was treated for ulcerative colitis with mesalazine and prednisolone without success. The colonoscopy showed multiple and confluent red-purple areas, which suggested vascular ectasias from the anus to the left flexure and grade 2 hemorrhoids. The computed tomography showed parietal thickening with scattered phleboliths in the same areas (● Fig. 1). Angiography revealed multiple venous ectasias and diffuse malformation of the whole inferior mesenteric vein. The results together confirmed the diagnosis of diffuse hemangioma of the rectum and left colon.

The patient completed an entire program of rubber-band ligation and sclerotherapy for the treatment of hemorrhoids and has been asymptomatic for 1 year.

This patient fits the profile of the typical patient with colonic hemangioma being misdiagnosed for 14 years. Gastrointestinal hemangiomas are usually found in young adults with a long history of recurrent painless rectal bleeding and iron deficiency anemia [2,3], and in rare cases they can cause massive bleeding [2,3]. The phleboliths represent thrombosed hemangiomas within or adjacent to the intestinal wall. The presence of phleboliths is pathognomonic and so computed tomography scan or magnetic resonance imaging are helpful to establish a definitive diagnosis [2-4].

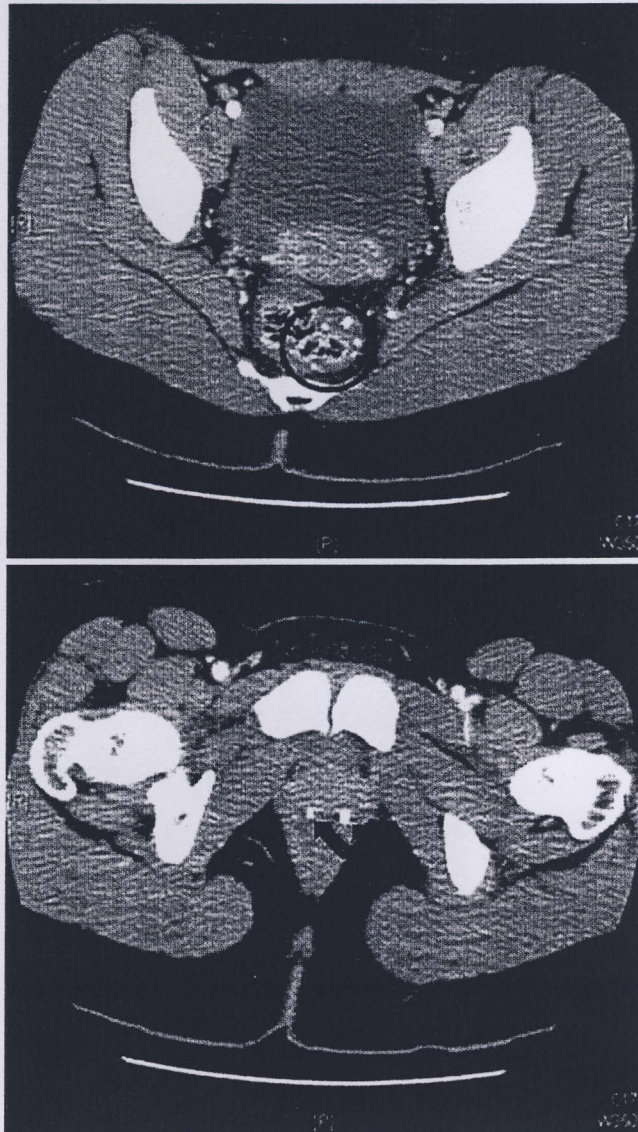


Fig. 1 The computed tomography image showed scattered phleboliths in a) the left colon (circle) and b) the rectum (arrows).

The definitive treatment is usually surgery, consisting of sphincter-preserving anterior resection with colo-anal anastomosis to grossly negative margins if possible [2-5]. If the lesions extend into the anal canal, an abdominoperineal resection is sometimes required [2-4], as would be the case in our patient. However, the benefits and the risks of this latter surgery should be weighted, especially in very young patients or those like the first patient from the article by Zurakowski et al. [1]. We considered that hemorrhoids could probably be the major cause of the rectal bleeding, as there was no proven evidence of hemangioma bleeding. We therefore decided to try again the instrumental treatment of hemorrhoids (rubber-band ligation and sclerotherapy), this time involving sequential treatments until all hemorrhoids had been successfully treated. This patient will probably need more sessions

than usual because the real problem remains – the inferior mesenteric vein malformation that will keep on overloading the hemorrhoidal plexus. Nevertheless, she may have a few more asymptomatic years before needing to decide to undergo a surgical treatment associated with appreciable morbidity.

Because hemangioma is a rare and probably, due to misdiagnosis, underestimated disease, there are few literature records about mortality. Mortality data that do exist refer to patients with extensive vascular malformations. Therefore, as suggested by Zurakowski, in severe cases needing aggressive surgery or in patient not eligible or refusing surgery, other alternatives should be tried.

DOI: 10.1055/s-2008-1077706

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