Digestive Haemorrhage on Unusual Colonic Ectopic Varices: A Case Report

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Abstract

Introduction: As ectopic variceal bleeding is a rare event in cirrhotic patients with portal hypertension, there are currently no precise recommendations for treatment. This report illustrates a rare case of a patient with acute bleeding on colonic varices.

Case Presentation: A 52-year-old woman was admitted in our hospital for acute bleeding in a context of non-diagnosed cirrhosis caused by alcohol consumption and chronic hepatitis C viral infection. The CT scan showed voluminous periaecal ectopic varices. Due to recurrence of bleeding despite medical treatment, an emergency right colectomy was performed.

Conclusion: As hemorrhage on ectopic varices is a life-threatening event in cirrhotic patients, more precise guidelines for management are needed.

Keywords: Portal hypertension, Ectopic varices, Variceal bleeding, Colonic varices

Introduction

Varicose veins associated with portal hypertension are porto-systemic anastomoses located predominantly in the oesophageal region; when they are outside this region, we speak of ectopic varices. More precisely, the prevalence of colonic varices has been found to be 34% to 46% in patients with cirrhosis [1]. As bleeding concerning this localisation is rare (2-5%) [2], the treatment is not well standardized, despite a high associated-mortality affected by the underlying severity of liver disease.

Case Presentation

A 52-year-old woman went to Périgueux's hospital emergency for hematemesis and melena. Hemoglobin concentration was 5.5 g/dl at entry. She had a history of chronic non-weaned ethylism with 17 units of alcohol per day, associated with a chronic hepatitis C viral infection linked with past intravenous drug use. After transfusion of 4 RBCs, the hemoglobin level was restored to 10.4g/dl. Patient didn't have a previous history of bleeding.

On arrival in the service, our patient showed initially no signs of hypovolemic shock, with blood pressure at 120/81 mmHg, hearth rate at 90 bpm. No clinical encephalopathy was found. The clinical examination showed a hepatomegaly without ascites.

Endoscopy performed in emergency showed grade 1 esophageal varices without red sign, associated with a discrete portal hypertension gastropathy. Entry biology resumed microcytosis, thrombocytopenia, normal blood ionogram and in particular normal urea, conserved renal function. Liver function deficiency was identified with total bilirubin at 11mg/l, increased ASAT to 4N, increased gGT to 6N. The TP was lowered to 38%. Total proteins were lowered to 57 g/l with serum albumin at 23 g/l.

Initial management included vasoactive treatment with the introduction of an octreotide electric syringe, ceftriaxone antibioprophylaxis, prevention of alcohol withdrawal syndrome and Gayet-Wernicke encephalopathy.

The evolution was unfavorable with recurrence at day 2 of digestive hemorrhage in the form of massive rectal bleeding, with tachycardia at 113bpm, blood pressure at 108/61mmHg, hemoglobin concentration at 6.6g/dl. A Computed Tomography (CT) scan performed in emergency found voluminous ectopic periaecal varices, performing a porto-cava anasotomy between the superior mesenteric vein and the umbilical vein on the one hand and the right ilio-femoral network on the other hand (Figure 1). No active bleeding was visualized. The aspect of the liver evocated advanced cirrhosis.

The patient was transferred urgently to the University Hospital of Bordeaux, where a haemostasis surgery by right hemicolectomy was performed. The operative sequences are simple and the patient leaves resuscitation after 5 days.

Discussion

Currently, in addition to medical support, various treatment options are available for ectopic variceal bleeding management, including endoscopic intervention, surgery, Transjugular Intrahepatic Portosystemic Shunt (TIPS), and angiographic embolization; however, no established therapy is recognized.

Endoscopic therapy has been described in colorectal variceal bleeding [3]. Endoscopy provides both diagnostic information and the potential for therapy.

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TIPS creation for ectopic variceal bleeding is supported by evidence, and is recommended in American guidelines [4,5].

Embolization can be performed alone with a transhepatic approach or in the same time of a TIPS procedure. Systemic reflux must be checked to avoid unwanted embolization in case of liquid agents such as glue use. New galenics could reduce the risk of unwanted embolization. In case of intractable bleeding, embolisation for rectal variceal bleeding with Gelfoam (Pharmacia and Upjohn Company, Kalamazoo, MI) has thus been described [6].

As the bleeding of our patient was active and massive, and localized in right colon, an endoscopic procedure was probably not the best option. TIPS and embolization, with embolization in the same time [7] or at least in case of intractable bleeding, could have been discussed in this patient, instead of surgery that is associated with high mortality in cirrhotic patients. Indeed, in a wide American study, colectomy even in a non emergency context, in cirrhotic patients with portal hypertension, had a 14.3 hazard ratio of mortality [8], highlighting the need of careful decision-making about surgery in these fragile patients. Surgery could remain an option only in instances in which all other approaches have failed. In all cases, the decision is dependent on individual expertise, location of the ectopic varice, and the technical feasibility.

References