

## Variceal hemorrhage of the colon secondary to pancreatic cancer



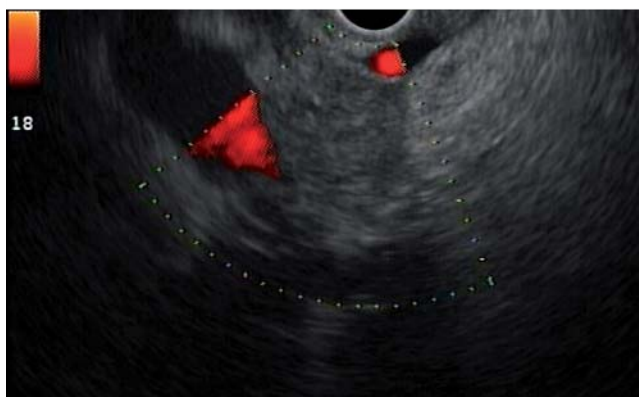
**Fig. 1** Endoscopic view of colonic lumen in a 71-year-old woman with previous segmental colonic resection for adenocarcinoma, who presented with hematochezia. Colonoscopy showed colon varices extending proximal to the anastomosis, with superficial venules (red wale markings).



**Fig. 2** Computed tomography image obtained after the administration of intravenous contrast showing prominent collateral vessels adjacent to the colonic anastomosis (white arrow), without signs of thrombosis. In addition, a nodular density adjacent to the pancreatic uncinus process was observed (black arrow).



**Fig. 3** Endoscopic ultrasound image showing a hypochoic pancreatic head mass, with 31 mm dimension and irregular margins.



**Fig. 4** Endoscopic Doppler ultrasound image demonstrating invasion of the spleno-portal confluence by the pancreatic mass, which generates a "stop" image on Doppler sign.

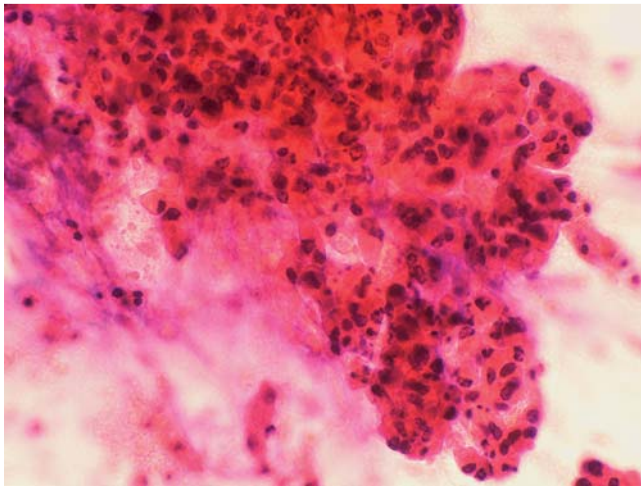
A 71-year-old woman was admitted due to recurrent lower gastrointestinal bleeding. She had undergone segmental colonic resection and adjuvant chemotherapy for colon adenocarcinoma 10 years earlier, without recurrence on follow-up. She reported experiencing several self-limited episodes of hematochezia over the past 6 months, without other symptoms.

Blood tests showed iron deficiency anemia (hemoglobin 9.9g/dL). Colonoscopy revealed dilated, tortuous, bluish vessels protruding into the lumen and extending proximal to the anastomosis, numerous superficial venules, and fresh blood and clots in the lumen (▶ **Fig. 1**). Hemostasis was achieved by adrenaline injection and hemostatic clips. Computed tomography angiography demonstrated prominent collateral vessels near the colonic anastomosis, without signs of thrombosis (▶ **Fig. 2**). In addition, a nodular density adjacent to the pancreatic uncinus process was noted, with superior mesenteric vessels involvement. Subsequent endoscopic ultrasound (EUS) showed a 31-mm hypochoic pancreatic head mass (▶ **Fig. 3**), with invasion of the spleno-portal confluence, generating a "stop" image on Doppler ultrasound (▶ **Fig. 4**). Transbulbar EUS-guided fine-needle aspiration (22-gauge needle) was performed. Pathologic analysis revealed pan-

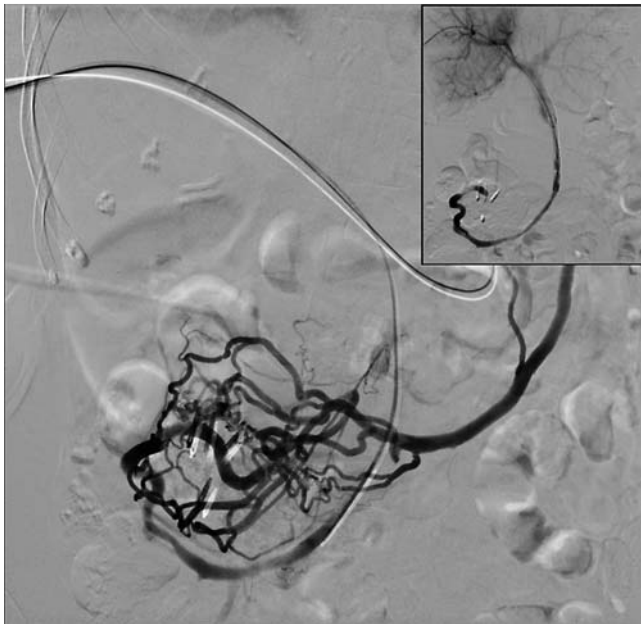
creatic ductal adenocarcinoma (▶ **Fig. 5**). Due to recurrent colonic bleeding, a vascular stent was placed through percutaneous transhepatic selective portography (▶ **Fig. 6**).

Colonic varices are a very rare cause of lower gastrointestinal bleeding, with a reported incidence of 0.07% [1]. Portal hy-

pertension is the most common etiology. Uncommon causes are congestive heart failure, mesenteric vein thrombosis, pancreatitis with splenic vein thrombosis, adhesions and, rarely, mesenteric vein obstruction [2]. It should prompt thorough evaluation, but can be idiopathic [1–3]. The present case is a peculiar con-



**Fig. 5** Photomicrograph of the endoscopic ultrasound-guided fine-needle puncture specimen, demonstrating epithelial cells in cohesive papillary aggregates, with altered nucleocytoplasmic ratio, consistent with the diagnosis of pancreatic ductal adenocarcinoma. (Hematoxylin and eosin,  $\times 40$ ).



**Fig. 6** Selective transhepatic portography showing superior mesenteric vein obstruction over a length of 3 cm and retrograde filling of varicose vein knot. A vascular stent was placed.

dition – a patient with previous segmental colectomy due to carcinoma, presenting with recurrent hematochezia as a result of variceal hemorrhage due to a second primary (pancreatic) carcinoma and

mesenteric obstruction. This case highlights the importance of considering colonic varices in the differential diagnosis of lower gastrointestinal bleeding and the importance of thorough investigation.

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**Competing interests:** None

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## Bibliography

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