

## Cavernous Haemangioma- Uncommon Per rectal Bleeding

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### Abstract

Haemangiomas are uncommon in GIT, but cavernous haemangiomas are relatively common. Therefore this report is a case of cavernous haemangioma in descending colon in a young male patient of 21 years present with colicky left upper abdominal pain and per rectal bleeding for 3 years. On clinical examination and imaging a pedunculated polypoid mass detected in descending colon. After laparotomy with left haemicolectomy a venous haemangioma found (confirmed by histopathology examination) surgical resection confirms this as benign tumor having good prognosis.

**Key words:** Cavernous haemangioma, per rectal bleeding, haemicolectomy, laparotomy.

### Introduction

Haemangiomas are uncommon in the gastrointestinal tract, but cavernous hemangiomas are the common type encountered.<sup>1</sup> Colonic cavernous hemangiomas most often involve the rectum and when symptomatic, often present with evidence of gastrointestinal bleeding.<sup>1</sup> Rarely, hemangiomas of the colon may form an exophytic mass, and patients may present because of the mass effect. This report reviews of colonic cavernous hemangiomas with the management of the involved colon.

### Clinical presentation

A young male patient of 21 years attend my private chamber on 15.10.11 with 3 year history of recurrent left side of upper abdominal pain and per rectal bleeding. Abdominal pain which was colicky stay for 3-4 days then pass a period of pain Free State of 20-30 days and same episode of pain appear again. Patient complains of recurrent bouts of clotted and fresh per rectal bleeding for same duration and bleeding start 2 days after abdominal pain and continues for 1-2 days then stop spontaneously. On clinical examination no abnormality was found except

slight tenderness in left lumbar region. Patient investigation done and findings was advised for CBC, urine for routine examination, ultrasonography of whole abdomen and barium enema of colon. Investigation report on 19.10.11 show normal CBC, urine and USG finding but barium enema of colon show persistent filling defect in descending colon (Fig-1). The patient given antispasmodic and antiulcerant (proton pump inhibitor) and advised for colonoscopy and biopsy for diagnosis of colonic mass. Colonoscopic finding of rectum and colon – seen upto caecum, there is a pedunculated polyp at 70 cm from the anal verge (Fig-2). Mucosa and vascular pattern of the rectum and colon appears normal. One piece of biopsy was taken and further biopsy was not possible due to profuse bleeding. Colonoscopic diagnosis was possible haemangioma of descending colon.

### Management approach

The patient was counseled about the disease condition and was decided for laparotomy, left haemicolectomy. Laparotomy with left haemicolectomy and primary anastomosis done. His postoperative recovery was uneventful. Resected specimen of colon exposed internally, show a pedunculaed growth (Fig-3) and sent for histopathological examination confirmed as cavernous haemangioma.

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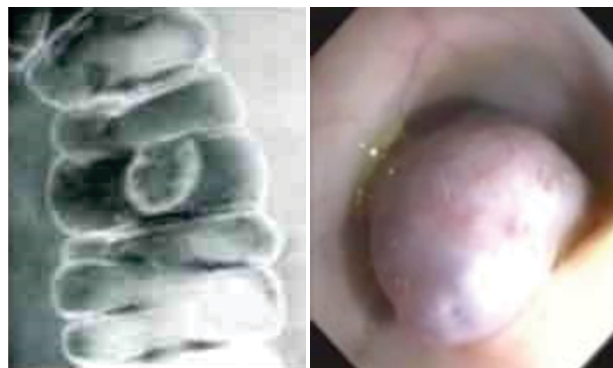
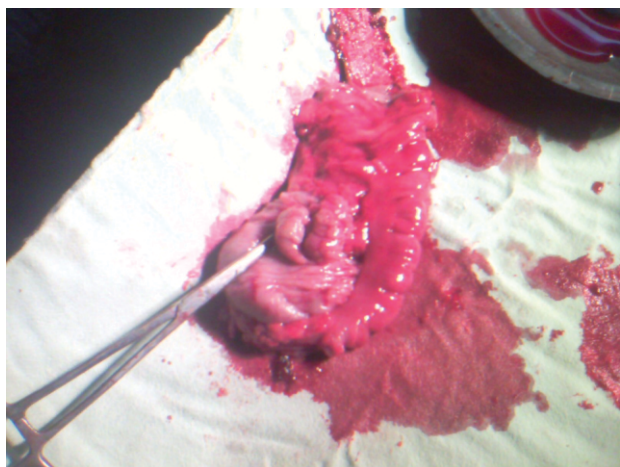


Figure 1a

Figure 1b



**Figure 2**

## Discussion

Colonic haemangiomas are the rarest tumors of the lower gastrointestinal (GI) tract. Intestinal haemangiomas are important because of their potential for causing massive hemorrhage.<sup>1,2,3,4,5,6</sup>

Cavernous haemangiomas of the colon, though rare, have been previously reported.<sup>7</sup> About 80% of colonic haemangiomas are found on histology to be of the cavernous subtype, with 70% occurring in the rectum.<sup>8</sup> Not surprisingly 60%–90% of patients present with bleeding from the rectum, but 17% will present with obstructive symptoms.

Cavernous haemangiomas have a tendency to run in families, and a high degree of clinical suspicion is needed to avoid unnecessary surgical procedures, which have been reported in upto 80% of patients, and delays in diagnosis upto 19 years.<sup>8</sup>

Early reports cite 40 to 50% mortality in untreated cases.<sup>1,9,10</sup> Death from exsanguination has been described.<sup>2,11</sup> These tumors are difficult to diagnose, and rectal lesions in particular are frequently misdiagnosed and mismanaged.

Investigations of the affected patients will be dictated by presenting symptoms. Obstructive large bowel symptoms warrant the use of barium enema or colonoscopy. Although angiography and scintigraphy may be useful, colonoscopy, CT colonography and magnetic resonance imaging are all more accurate methods for establishing the diagnosis, but with colonoscopy considered to be the method of choice.<sup>12</sup> Compared with optical colonoscopy, CT colonography has the advantage of greater accuracy in determining wall thickening and extramural extension.<sup>8</sup>

Complete resection is the definitive therapy for symptomatic colonic haemangiomas. This usually means a segmental bowel resection at open or laparoscopic surgery, as most patients have diffuse infiltrative lesions. The presence of a polypoid mass of appropriate size may lend

itself successfully to endoscopic polypectomy or endoscopic mucosal resection.<sup>13</sup> Localized flat lesions can be treated with endoscopic laser therapy or sclerotherapy with systemic steroid or interferon therapy with variable results.<sup>14</sup> Complete surgical resection results in a good prognosis for these benign lesions.

## Conclusion

Early diagnostic colonoscopy can be considered the best procedure as surgical management. Colonic haemangioma can also be considered as an open operative intervention or by endoscopic.

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