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CASE REPORT

Diffuse cavernous hemangioma of the rectosigmoid colon mimicking ulcerative colitis (with video)

Ülseratif koliti taklit eden rektosigmoid kolon diffüz kavernöz hemanjiyom

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Diffuse cavernous hemangioma of the rectosigmoid colon is a rare benign vascular lesion. The rectosigmoid colon is the most common site of this disease. It affects mainly young adults. The most frequent symptom is rectal bleeding, which can be confused with hemorrhoids, perianal diseases and ulcerative colitis. We present a case of diffuse cavernous hemangioma of the rectosigmoid colon mimicking ulcerative colitis.

Key words: Diffuse cavernous hemangioma, rectal bleeding, vascular lesions, colonic disease

Diffüz kavernöz hemanjiyom nadir görülen benign vasküler lezyondur. Rektosigmoid kolon bu hastalığın en sık görüldüğü bölgedir. Esas olarak genç yetişkinleri etkiler. En sık görülen semptomu hemoroid, perianal hastalıklar ve ülseratif kolit ile karıştırılabilen rektal kanamadır. Biz bu makalede ülseratif koliti taklit eden bir diffüz kavernöz hemanjiyom vakasından bahsedeceğiz.

Anahtar kelimeler: Diffüz kavernöz hemanjiyom, rektal kanama, vasküler lezyonlar, kolon hastalığı

INTRODUCTION

Diffuse cavernous hemangioma of the rectosigmoid colon (DCHRC) is a rare disease that usually affects young adults. Rectal bleeding is the main symptom. Bleeding can be acute, chronic or recurrent. As it is often misdiagnosed as hemorrhoids, it causes delayed diagnosis and unnecessary surgeries. DCHRC can sometimes be confused with adenomatous polyps, rectal varices, and ulcerative colitis (1). In this article, we present a case of DCHRC mimicking ulcerative colitis.

CASE REPORT

We present a 23-year-old man who has been experiencing recurrent episodes of rectal bleeding for two months. A rectosigmoidoscopy was done at another centre one month ago and he was diagnosed with ulcerative proctitis. The patient was treated with oral and rectal mesalazine, but he applied to our center for ongoing recurrent bleeding. He had no further symptoms like abdominal pain or fever. Nonetheless, he developed severe anemia due to frequent episodes of recurrent rectal bleeding and needed several blood transfusions before being referred to our hospital.

The patient's history revealed that angiography with embolization was performed due to spinal hemangioma, and there were multiple hemangiomas smaller than 1 cm in the liver. Rectal examination revealed a soft palpable mass from the anal verge. The laboratory test confirmed an iron deficiency anemia. Inflammatory parameters were normal. The patient's colonoscopy revealed diffuse, elevat-

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ed, and tortuous vascular lesions that extended from the sigmoid colon (35 cm from the anal verge) to the lower rectum **(Figure 1-with video)**. The patient underwent selective embolization of the superior rectal vessels. Endovascular embolization of arterial vessels of hemoangioma with microspheres was performed. The bleeding was stopped after the embolization treatment **(Figure 2-with video).** Segmentary resection of the affected segment was planned for the patient. Informed consent was given from the patient.

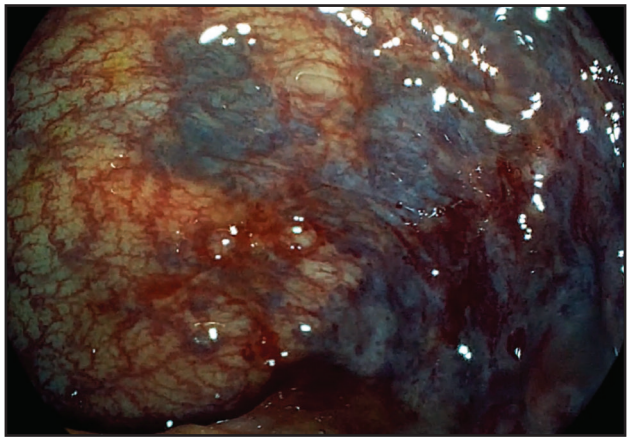

Figure 1 Colonoscopic image of diffuse cavernous hemangioma in rectosigmoid colon, i-scan imaging **(video)**.

https://akademik.tgv.org.tr/videos/hemanjiyom.html

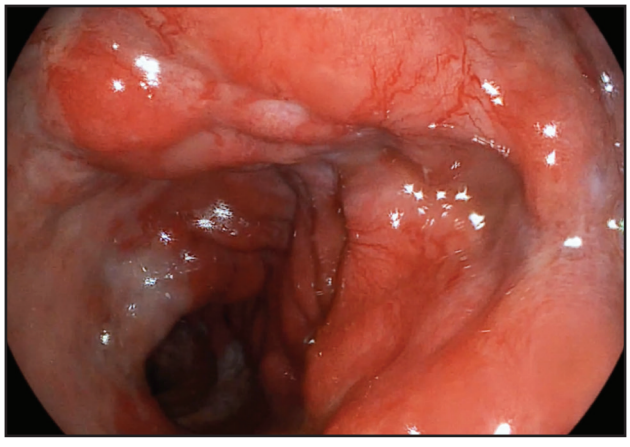

Figure 2 Diffuse cavernous hemangioma after the embolisation treatment **(video)**.

https://akademik.tgv.org.tr/videos/hemanjiyom.html

DISCUSSION

According to Pohlen, the incidence of gastrointestinal angiomas is 0.3% and is classified into five categories: Phlebectasias, cavernous hemangioma, diffuse infiltrating cavernous hemangioma, polypoidal cavernous hemangioma and capillary hemangioma (2). Diffuse cavernous hemangioma (DCH) is considered a progressive intestinal hamartoma. DCH of the colon, first described by Philips in 1839, is rare and mostly affects the rectosigmoid region (3). It causes acute, chronic and recurrent bleeding in patients. Since it is seen at an early age, its symptoms can often be attributed to internal hemorrhoids, polyps, or ulcerative colitis. This results in a long time between symptoms and diagnosis for these patients (4).

Diagnosis of the disease is made by demonstrating dilated and tortiosed venous structures in the rectosigmoid colon, sometimes severe mucosal hyperemia and erosions can be seen and can be confused with ulcerative colitis, as in our patient. In addition, phleboliths can be seen on x-ray and cross-sectional imaging (5). In acute bleeding, angiography with embolization can be beneficial, but extravasation is not always visible and recurrence is a rule. Controlling bleeding mostly requires a complete surgical resection. Non-surgical techniques such as sclerotherapy, cryotherapy or argon plasma coagulation were used. These procedures are only appropriate for lesions that are well-defined and small, otherwise the bleeding will recur (4,6).

Oner and Altaca recommended lower anterior resection for the treatment of rectosigmoid hemangioma in 1993 and remains the current standard of care for this disease, as it preserves the sphincter, which is important for maintaining quality of life (7). Preoperative embolization has been applied in recent years due to the presence of massive intraoperative bleeding in some patients (8). To prevent intraoperative bleeding, embolization was done in

our patient. After the procedure, there was not occurred any bleeding.

Our patient had spinal hemangioma along with colonic hemangioma. The association between spinal and gastrointestinal hemangiomas may suggest a systemic disorder of angiogenesis. Various familial disorders accompanied by multiple venous malformations have been described in the literature (9).

In conclusion, DCHRC should be considered and evaluated in addition to common diseases such as hemorrhoids, perianal diseases, and ulcerative colitis in patients presenting with acute, chronic or recurrent bleeding at a young age. In patients with hemodynamic instability due to severe bleeding, selective embolization can be performed preoperatively.

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