SHORT REPORT

A rare cause of rectal bleeding masquerading as proctitis

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Abstract

Background and aims: Diffuse cavernous haemangioma of the rectum (DCHR) is a rare benign vascular neoplasm that affects mainly young adults and can present with rectal bleeding or massive haemorrhage. We report a case of DCHR masquerading as proctitis which was diagnosed many years ago following colonoscopy. This is the first case where the DCHR was resected with subsequent formation of a colonic J pouch versus conventional colo-anal anastomosis in order to maintain good bowel function.

Method: Clinical case report including a review of current literature regarding DCHR.

Results: This is one of few cases of DCHR reported that was initially misdiagnosed as proctitis.

Conclusions: Awareness of this rare condition is important when investigating patients presenting with rectal bleeding to prevent unnecessary treatment and delay surgery. Prompt intervention is necessary to prevent severe rectal haemorrhage.

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1. Introduction

DCHR of the rectum is a rare benign vascular neoplasm that affects mainly young adults and can present with anaemia, recurrent painless rectal bleeding and even massive haemorrhage.1–3 This was first described by Phillips in 18394 and subsequently in case reports and small case series.1–5

2. Case report

A 27 year old male was admitted with a one month history of worsening painless fresh rectal bleeding. He also reported extreme fatigue and dizziness. There was neither a history of recent travel abroad nor any exposure to antibiotics in the
Figure 1  Endoscopic findings of DCHR: Multiple red-blue nodules (arrows) with vascular congestion and bleeding.

Figure 2  a. CT findings of DCHR: symmetrically, markedly thickened rectal wall with multiple calcification foci representing phleboliths (arrow). b. MRI findings of DCHR (coronal oblique T2 weighted): increased T2 signal of rectal wall thickening. Both the signal voids corresponding to phleboliths (white arrows) and diffuse mesorectal hyperaemia (black arrow) differentiate this entity from neoplasia.
previous 3 months. At age 17 he had been diagnosed with proctitis at another hospital but had been lost to follow-up. On presentation he reported a 10 year history of episodic rectal bleeding lasting several weeks at a time which would resolve spontaneously. As he always felt well he was reluctant to seek medical advice.

Initial assessment revealed pale conjunctivae, with no evidence of an acute abdomen and there was bright red blood on the glove during rectal examination. Laboratory tests revealed haemoglobin of 5.3 g/dl (13–17) and a ferritin of 6 ng/ml (15–120) with normal inflammatory markers including CRP and ESR. Plain radiographic imaging of the chest and abdomen was unremarkable. He was transfused blood in view of his symptomatic anaemia.

Flexible sigmoidoscopy was performed to assess his previously diagnosed proctitis and exclude other causes of bleeding. This revealed multiple bluish purple submucosal nodules in the rectum, representing dilated tortuous blood vessels characteristic of a DCHR (Fig. 1). CT and MR imaging were subsequently performed to assess this further (Fig. 2). The patient underwent a lower anterior resection with formation of a colonic J pouch with a defunctioning ileostomy. Macroscopic and histological analysis of the surgical specimen confirmed DCHR with no evidence of inflammatory bowel disease (Fig. 3). Since reversal of his ileostomy the patient has had no further rectal bleeding and is opening his bowels two to three times a day with no faecal incontinence.

3. Discussion

Rectal bleeding is a common problem encountered in clinical practice with a multitude of causes. Appropriate assessment is essential to make the right diagnosis so the correct treatment can be instigated. This case reveals a very rare cause of rectal bleeding from a DCHR that was initially diagnosed as proctitis following a colonoscopy 10 years previously.

DCHR maybe misdiagnosed as proctitis, internal haemorrhoids or carcinoma.\(^2,3\) The appearance at endoscopy may be misinterpreted as proctitis since the supply vessels may become obstructed by multiple thrombi causing rectal ischaemia leading to chronic inflammatory changes, mucosal oedema and ulceration.\(^1\) We speculate these features seen at initial colonoscopy may have led to a diagnosis of proctitis.

Diagnosis of DCHR should be made from a combination of clinical history, endoscopic findings, and cross sectional imaging preferably MRI to avoid diagnostic medical radiation exposure. Histologically there are characteristic features\(^5\) but endoscopic biopsy should be avoided because of risk of severe haemorrhage. The treatment of choice for DCHR is pull-through transection and colo-anal anastomosis since non-operative therapies such as sclerosing injection, endoscopic mucosal resection and radiotherapy do not appear to be successful.\(^1,3\) However, our patient had a colonic J pouch anal anastomosis to reduce frequency of defaecation. To our knowledge this is the first case of DCHR treated with a colonic J pouch to maintain bowel function which is usually performed in the treatment of rectal cancer. Since reversal of his ileostomy the patient is satisfied with his bowel frequency which remains at two to three times a day.

DCHR is a rare but an important differential in the assessment of rectal bleeding because of its risk of massive haemorrhage and should also be considered in patients with a history of proctitis to avoid unnecessary treatment.

Conflict of interest

None.
References


