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 uncinate process was noted, with superior mesenteric vessels involvement. Subsequent endoscopic ultrasound (EUS) showed a 31-mm hypoechoic pancreatic head mass (Fig.3), with invasion of the splenoportal confluence, generating a “stop” image on Doppler ultrasound (Fig.4). Transbulbar EUS-guided fine-needle aspiration (22-gauge needle) was performed. Pathologic analysis revealed pancreatic 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 hypertension 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-
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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**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, ×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.