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-

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**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 uncinate process was observed (black arrow).

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

**Fig. 4** Endoscopic Doppler ultrasound image demonstrating invasion of the splenoportal confluence by the pancreatic mass, which generates a “stop” image on Doppler sign.
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.

**References**


**Bibliography**


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