Ectopic perianal varix in a patient with portal hypertension: a rare cause of hematochezia

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Dear Editor:

A 75-year-old woman with diabetes and liver cirrhosis (Child-Pugh A) related to nonalcoholic steatohepatitis presented in the emergency department with hematochezia. On physical examination, she had normal vital signs, was mildly confused and had a slow speech. In the anal verge, there was a large subcutaneous nodule, bluish and soft, that seemed like a huge congested external hemorrhoid. The laboratory panel was remarkable for anemia (hemoglobin 6.0 g/dl, normal mean corpuscular volume), low platelet count ($128.000/\text{mm}^3$), and prolonged INR (1.33). The gastroscopy showed small-sized esophageal varices and mild portal hypertensive gastropathy without bleeding stigmata or luminal blood. At ileocolonoscopy, rectal varices were identified without current or recent bleeding stigmata and there was no luminal blood. After transfusion of two units of packed red blood cells, hemoglobin increased to 9 g/dl and the patient became oriented and with a coherent speech. As the patient was about to be discharged, she referred new onset hematochezia. This time, a continuous spurting hemorrhage was observed originating from the perianal nodule. After local anesthesia with lidocaine, 2 cc of cyanoacrylate were injected with successful hemostasis and without embolic complications. The endoscopic ultrasound, performed with a radial instrument (Olympus GF160 AL5), confirmed obliteration of blood flow in the anal verge sclerosed varix and showed rectal varices communicating with the superior rectal vein through a perforating vein.

Ectopic varices are portosystemic venous collaterals that appear anywhere other than the esophagogastric region and

are responsible for 1–5 % of variceal bleeding [1]. The recognized sites of ectopic varices are the duodenum, jejunum, ileum, colon, rectum, peristomal area, biliary tree, peritoneum, around the falciform ligament, umbilicus, urinary bladder, along the splenic ligament, ovary, vagina, and right diaphragm [2]. To the best of our knowledge, this is the first reported case of a bleeding ectopic perianal varix. This case underlies the importance of a high index of suspicion to correctly diagnose an ectopic source of rectal bleeding in a patient with portal hypertension. In fact, the lesion's similarity to a huge external congested hemorrhoid was misleading and if the bleeding had not recurred, this unusual source of hemorrhage could have been missed. The best therapy for ectopic varices is still undefined and, currently, the selected treatment depends on the local expertise, location and severity of bleeding, liver function and the patient's comorbidities [1, 2]. In this case, injection sclerotherapy with cyanoacrylate was a successful and safe option.

Conflicts of interest All the authors disclose no financial or personal conflicts of interest relevant to this publication.

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