



# Rectal Variceal Hemorrhage Requiring Treatment With Endoscopic Band Ligation

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## Objectives

- Demonstrate a case of clinically significant bleeding rectal varices.
- Offer possible treatment approach for symptomatic rectal variceal bleeding.

## Introduction

Acute variceal hemorrhage is a gastrointestinal emergency and a major cause of death in cirrhotics.

We present a rare case of rectal variceal hemorrhage causing clinically significant bleeding.

## Case Description

A 38 year old with alcohol use disorder presented with jaundice and confusion.

On vital signs he was afebrile, with a blood pressure of 116/54 mmHg which downtrended to 94/40, heart rate of 98 beats per minute, tachypnea to 22 breaths per minute and saturating 100% on room air.

He was ill-appearing, unable to follow commands, with scleral icterus, abdominal distention with positive fluid wave and anasarca.

He had a hemoglobin of 3.7 g/dL, platelet count of 100 K/mcL, creatinine of 1.9 mg/dL, total bilirubin of 36.3 mg/dL, lactate of 9.9 mmol/L, ammonia of 82 mcmol/L and INR of 4.3.

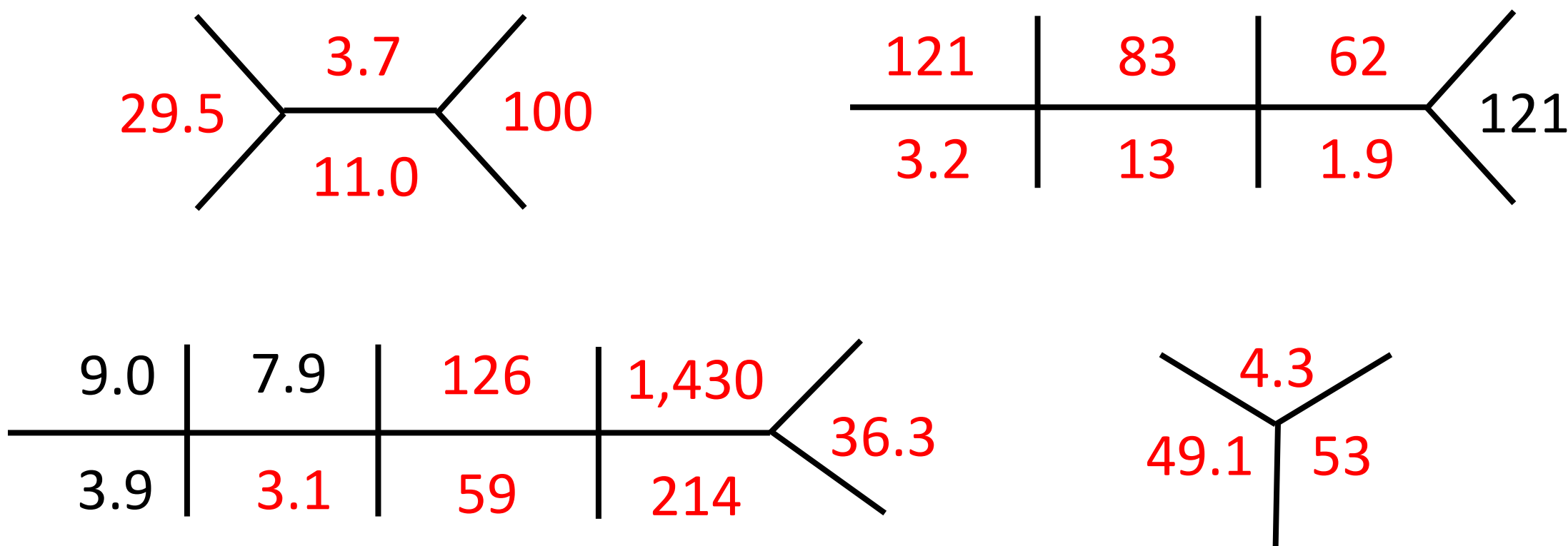


Figure 1. Fishbone diagrams of patient's initial laboratory values

## Hospital Course

Computed tomography of the abdomen and pelvis with contrast showed a cirrhotic appearing liver, portal venous hypertension, moderate ascites and mesenteric varices.

He was transfused 2 units of packed red blood cells (pRBC) with improvement in hemoglobin to 7 and initiated on treatment for decompensated cirrhosis.

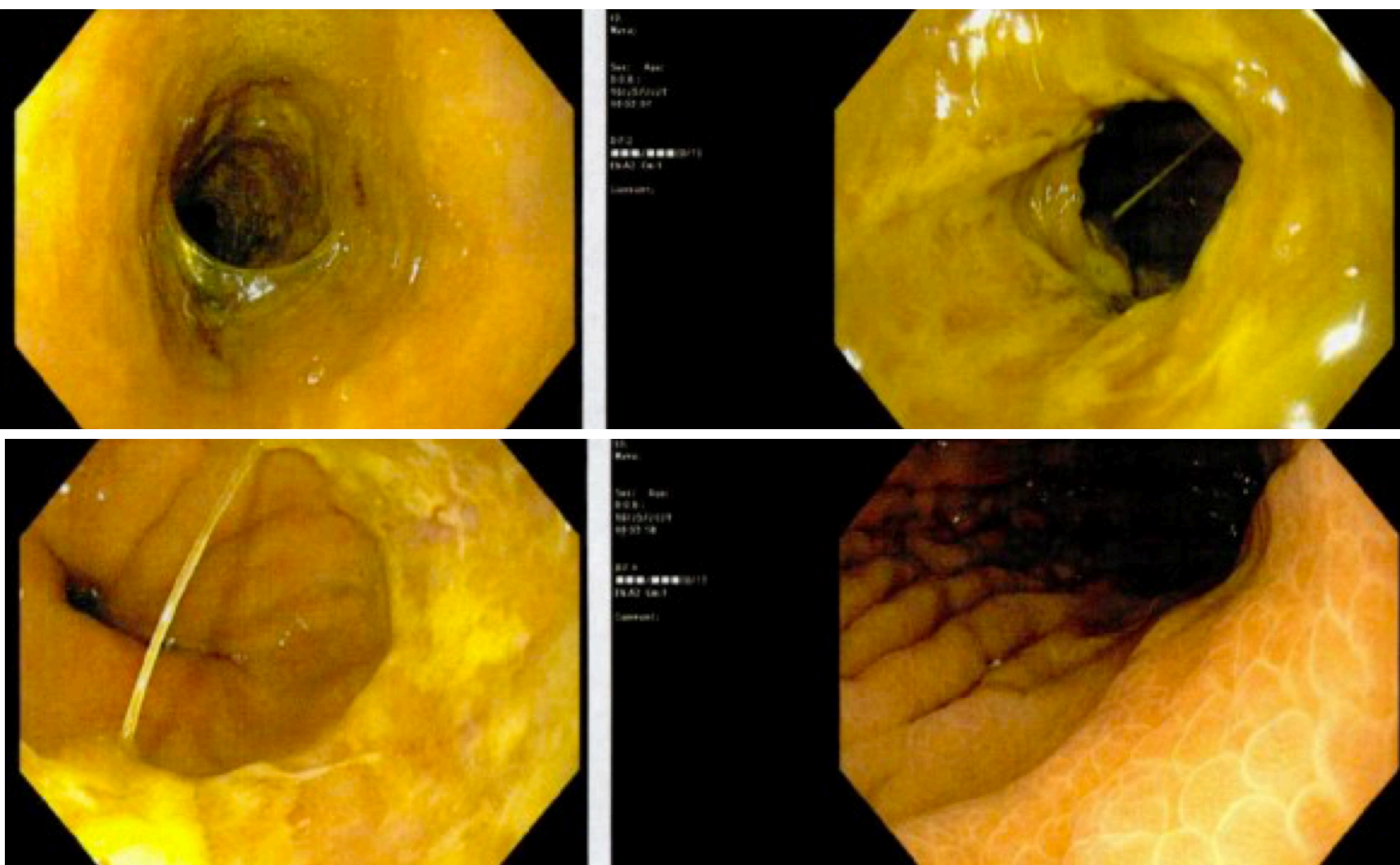


Figure 2. Esophagogastroduodenoscopy (EGD) demonstrating no evidence of varices or ulcerations

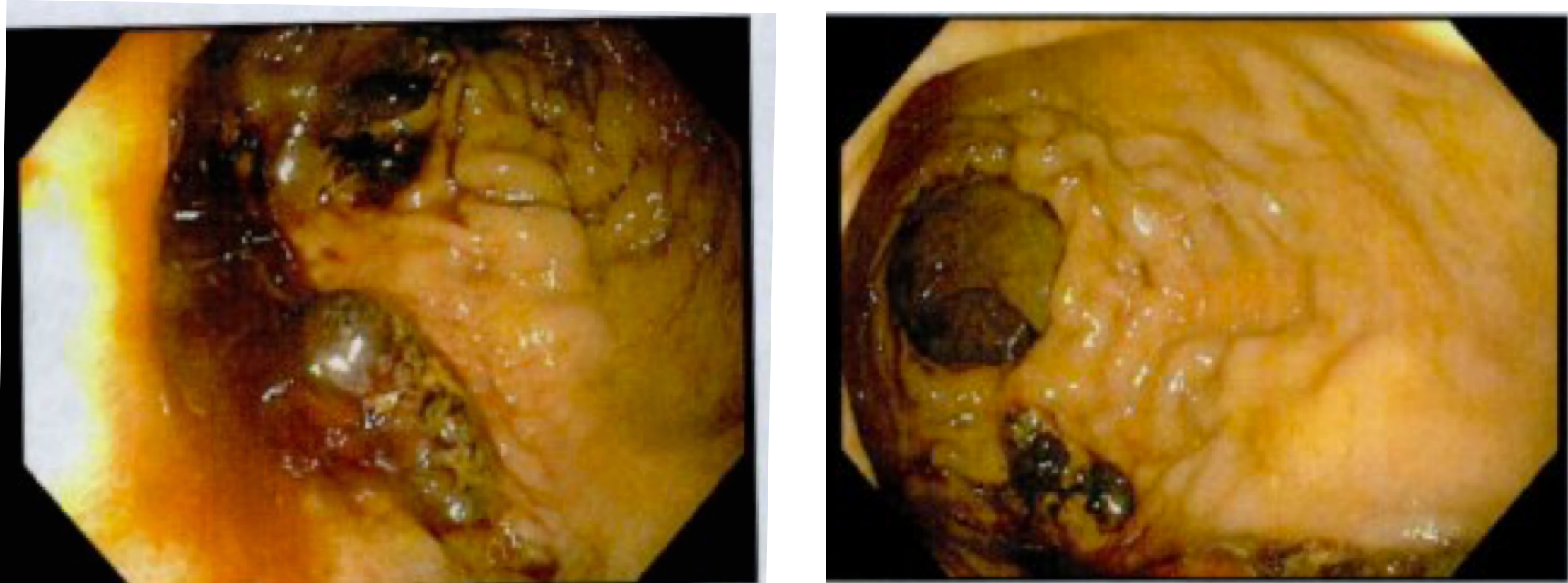


Figure 3. Colonoscopy revealing presence of rectal varices with bleeding.

## Case Conclusion

Gastroenterology was consulted for esophagogastroduodenoscopy (EGD).

The EGD found grade D esophagitis without evidence of varices or ulcerations.

Despite lactulose and rifaximin, his encephalopathy worsened and he was intubated for airway protection.

His stool became increasingly saturated with blood and his hemoglobin continued to downtrend.

He required a total of 9 units of pRBCs over the course of 4 days.

A repeat EGD found no varices.

Colonoscopy was performed which revealed 5 tortuous bleeding rectal varices that were band ligated.

Transfusion requirements dramatically decreased post-procedure.

## Discussion

Due to rarity, there are no established guidelines for treatment of rectal varices as opposed to esophageal varices.

Unlike bleeding gastroesophageal varices, no randomized control trials have shown proven benefit for use of vasoactive drugs such as octreotide in bleeding rectal varices.

Management of rectal varices can include methods involving endoscopy, interventional radiology or surgery. One retrospective study showed that endoscopic injection sclerotherapy has greater efficacy compared to endoscopic band ligation with less rebleeding rate. However, another study showed endoscopic band ligation to be superior. Additional procedures such as transjugular intrahepatic portosystemic shunt with or without embolization and balloon-occluded retrograde transvenous obliteration have also demonstrated resolution of acute bleeding.

Failure of these methods leads to surgical treatment such as suture ligation and porto-caval shunt.

We achieved hemostasis with endoscopic variceal ligation.

## Conclusions

Rectal variceal hemorrhage can be an uncommon cause of gastrointestinal bleeding in a cirrhotic patient.

Multiple methods of management exist including endoscopic band ligation which was successful in our patient.

## Contact

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