Thinking outside the box in lower gastrointestinal bleeding

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Case Presentation

A 78-year-old man with prior medical history of chronic kidney disease and atrial fibrillation under apixaban but no recent abdominal trauma presented to the emergency department due to acute abdominal pain. The physical examination was unremarkable except for a distended hypertympanic abdomen with normal bowel sounds and painful upper quadrants of the abdomen with no signs of peritoneal irritation. Laboratory evaluation revealed mild anemia, leukocytosis and elevated C-reactive protein. The patient underwent computed tomography (CT) scan which showed a circumferential bowel wall thickening of the terminal ileum and cecum with fat stranding. A conservative medical treatment was chosen including intravenous antibiotics with partial improvement. Within 11 days of admission, the patient developed melena followed by hematochezia. Upper endoscopy showed no signs of bleeding while colonoscopy (Figure1) revealed an endoluminal dark red-brown mass partially covered by necrotic and yellowish mucosa in the cecum with extensively ulcerated surrounding mucosa. Ileoscopy was not possible since the mass obstructed the ileocecal valve. An angio-CT (Figure 2) was then performed showing a 58x29x37mm hyperdense mass with no signs of active bleeding or thickening of the ileocecal wall.

Given the clinical, endoscopic, and imaging findings, what is the most likely diagnosis?

- Ischemic colitis
- Infectious colitis
- Crohn's disease
- Intramural hematoma
- Colon adenocarcinoma

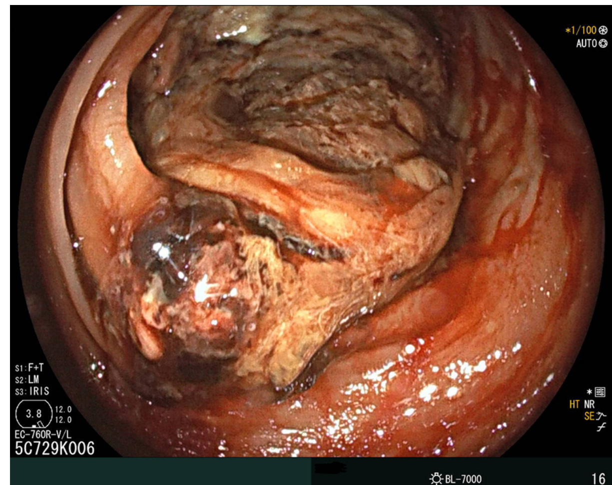

Fig. 1.

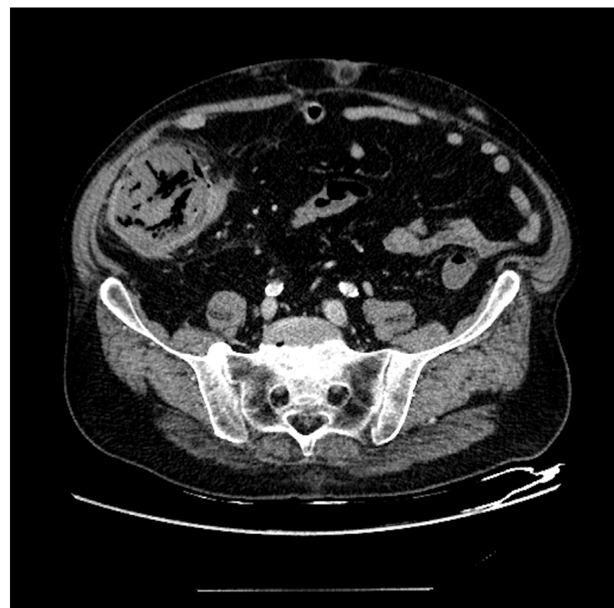

Fig. 2.

Discussion

The diagnosis of colonic spontaneous intramural hematoma was established. A conservative approach was adopted with the withdrawal of anticoagulation. No relapse of gastrointestinal bleeding occurred.

Colonic intramural hematomas are rare, with most cases being secondary to trauma. Anticoagulation is a primary risk factor for nontraumatic spontaneous hematomas. Patients often present with nausea, vomiting, abdominal pain, or hematochezia. The diagnosis of parietal hematomas can be presumed during an endoscopic evaluation and confirmed by imaging methods. Due to the limited number cases reported in the literature, the endoscopic and radiologic appearance remains poorly described (1). Given the risk of complications, suspicion for an early diagnosis is crucial for improving the prognosis. The majority of colonic hematomas

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should undergo a “watch and wait” approach. Surgery is only indicated in complicated cases or if there is no spontaneous resolution (2).

References

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