

Colonoscopy as a therapeutic option for acute after sigmoidectomy rectal bleeding

Colonoscopia como opción terapéutica ante rectorragia aguda tras sigmoidectomía

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To the Editor,

This is the case of a 58-year-old man with a past medical history of appendectomy diagnosed as part of a colorectal cancer screening program through colonoscopy with a nipple-like ulcerated lesion located 25 cm away from the anal margin. Biopsy results revealed the presence of adenocarcinoma, and staging studies showed no evidence of spread. The patient was scheduled for laparoscopic sigmoidectomy with end-to-end mechanical anastomosis using an ILS 29 circular stapler. The specimen resected was extracted through a Pfannenstiel incision, with Penrose drain placement in the pelvis. The surgery was uneventful.

In the immediate postoperative period, a few hours after surgery, the patient experienced 2 episodes of overt rectal bleeding without hemodynamic repercussions, but with a gradual drop of hemoglobin levels (14.3 g/dL, 13 g/dL, 12 g/dL). Due to persistent anemia, an emergency coronary computed tomography angiography was performed that revealed contrast extravasation in the arterial phase inside the rectum, specifically at the colorectal anastomosis site. Contrast extravasation increased in the venous phase, which was indicative of active bleeding. No fluid was seen in the pelvis.

An on-call gastroenterologist was consulted for early therapeutic colonoscopy in the endoscopy suite, along with an anesthesiologist and a surgeon. During

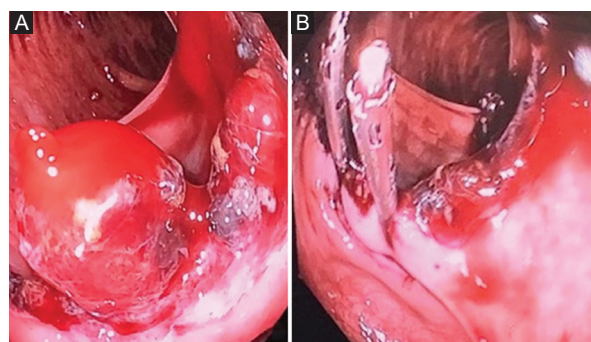


Figure 1. A: colonoscopic image. At 6 h, bleeding in an active arterial jet is observed. B: endoscopic treatment. Mechanical zipper closure with five hemoclips on the staple line.

the colonoscopy, the anastomosis was identified 18 cm away from the anal margin, with significant fresh bleeding. An active arterial jet of blood was seen at the staple line of the anastomosis at the 6 o'clock position (Fig. 1 A). After washing the anastomotic region, the blood clot was removed using a tripod snare, and 6 mL of epinephrine 1:10,000 were infused. Mechanical zip closure was performed using 5 hemoclips along the staple line (Fig. 1 B) that successfully stopped the bleeding leaving a stable suture line without active bleeding.

The patient was, then, transferred to the recovery room where he remained hemodynamically stable at all times, without amines and with hemoglobin levels

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of 10.4 g/dL. Since the postoperative period was uneventful, the patient was discharged 6 days after surgery.

Severe bleeding from a colorectal anastomosis is a rare complication. Its incidence rate is close to 1% according to the medical literature available¹. The rate of therapeutic effectiveness of colonoscopy is almost 81% being good prognostic factors the use of hemoclips and bleeding within the first 5 days after surgery. No correlation has been reported between early colonoscopy and the development of anastomotic dehiscence².

This case highlights the importance of considering early therapeutic colonoscopy as an option in cases of acute postoperative rectal bleeding. This technique facilitates the direct visualization of the lesion and the performance of therapeutic interventions to manage bleeding lesions, and potentially avoid the need for surgical procedures³.

Performing an early colonoscopy and the use of hemoclips is a safe and efficient approach to manage severe rectal bleeding as a complication of colorectal surgery^{1,4}.

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Conflicts of interest

None reported.

Ethical disclosures

Protection of human subjects and animals in research. The authors declare that no experiments were performed on humans or animals for this study.

Patients' data protection. The authors declare that they have followed the protocols of their work center on the publication of patient data.

Right to privacy and informed consent. The authors have obtained the written informed consent of the patients or subjects mentioned in the article. The corresponding author is in possession of this document.

References

1. Besson R, Christidis C, Denet C, Bruyns L, Levard H, Gayet B, et al. Management of postoperative bleeding after laparoscopic left colectomy. *Int J Colorectal Dis.* 2016;31:1431-6.
2. Liu W, Lin D, Zhong Q, Su M, Li J, Guo X, et al. Endoscopic management of postoperative anastomotic bleeding in patients with colorectal cancer. *Int J Colorectal Dis.* 2020;35:1703-9.
3. Ledo Barro L, Ulla Rocha JL. Información al paciente. Colonoscopia. *Rev Esp Enferm Dig.* 2008;100:372.
4. Amr MA, Alzghari MJ, Polites SF, Khasawneh MA, Morris DS, Baron TH, et al. Endoscopy in the early postoperative setting after primary gastrointestinal anastomosis. *J Gastrointest Surg.* 2014;18:1911-6.