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# 60 Years Old Female with Massive Large Intestinal Bleeding

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This is an account of a case of massive lower G.I.T. bleeding which required emergency total colectomy as a life saving procedure but left us in a state of confusion as far as final diagnosis is concerned. Although, it did prove the importance of some sophisticated investigations which are not being followed as a routine but without which a pin point diagnosis can not be made.

Mr. Zakrya Shah 60 years hakim by profession father of 17 healthy children came in emergency on 13-11-86 with history of fresh bleeding per rectum for last four hours leading to fainting & severe weakness. Although he had been having dysentry like attacks for past 7 years but he had never passed fresh blood per rectum previously.

Upper G.I. bleeding was ruled out by endoscopy and fresh transfusions given to stabilize the patient. The clinical data of the patient were as follows:–

| | |
|---|---|
| Pulse | 102 |
| BP | 110/70 (Supine) |
| | 90/70 (Sitting) |
| Pallor | + + + |
| Hb | 4.8 gm% |

Bleeding time, clotting time, prothrombin time and liver function tests were with in normal limits. Fresh bleeding per rectum continued. Proctoscopy revealed the blood to be coming from high up. Transfusion of 2500 cc of fresh blood over a period of 24 hours, failed to stabilize the circulatory status of the patient. His pulse rose to 130/min & Hb went down to 3 gm%. Emergency laparotomy was performed.

At operation, the site of bleeding was immediately localized to the colon. The colon was distended in whole of its extent, it was oedematous, thin walled and friable with most of the blood present in the ascending colon. No evidence of diverticulosis or any other focal lesions of colon were present. The liver was rather pale, greasy, enlarged. Normal spleen stomach and small gut were observed. A decision of total colectomy was made and as soon as the colon was isolated the patient became stabilized. Total colectomy leaving behind the distal 2/3rd of rectum was accomplished.

The rectal stump was oedematous therefore, end iliostomy was prefered to ileorectal anastomosis. After the completion of operation whole of the colon was opened along its antimesenteric border no focal lesion was visible except for red & velvety appearance of the muscosal surface.

Post operatively the patient had a smooth recovery.

## DISCUSSION.

DR. SULTAN TARAR *(Asstt. Prof. Surgery)* There are several causes of lower G.I.T. bleeding:

| **Causes of colonic bleeding** | **Causes of rectal bleeding** |
|---|---|
| 1. Carcinoma. | 1. Haemorrhoids. |
| 2. Diverticulosis. | 2. Anal fissure. |
| 3. Vascular ectasia. | 3. Proctitis. |
| 4. Colitis. | |
| 5. Polyps. | |
| 6. Ischemic Colitis. | |

Blood was present in whole of the colon and colonic isolation stabilized the patient, no other causes of bleeding were found. Diverticulosis is rather uncommon in this part of the world & the colon had no evidence of diverticulosis. No focal lesion was seen in the colon Polyp and carcinoma as a cause of bleeding were, therefore, ruled out. Only the following possibilities were considered in the differential diagnosis.

1. Ulcerative Colitis.
2. Vascular Ectasias.
3. Ischemic Colitis.

The possibility of early toxic megacolon could not be ruled out. But I think that the patient was suffering from vascular ectasia on the following reasoning:–

1. There was no history of sudden increase in the number of stools before the episode of this bleeding.
2. The pathologist was unable to find any ulcer in the colon.
3. It is the commonest casue of colonic bleeding in patients over 50 years.
4. Skin angiomas are not associated with this lesion & none were present in this case.
5. Caecum & ascending colon are involved.
6. It is a degenerative lesion of capillaries and venules size of lesion is usually less than 5mm.
7. It can be diagnosed by angiography and on colonoscopy (when patient not bleeding briskly).
8. It is unidentifiable at surgery.
9. Itis unidentifiable by the pathologist, on gross examination, unless contrast examination with silicon ruber is done.

PROFESSOR MAHMOOD *(Prof. Surgery)* I am sure that the patient was suffering from ulverative colitis. We know that ulcerative colitis is a much more wide spread disease than the reported number of cases but sometimes its mild clinical manifestations are confused with infective diarrhea and for some 3–4 loose stool with a little bit of mucus and blood is a normal routine. I have seen large number of cases of ulcerative colitis during my stay abroad and based on that experience and operative findings mainly consisting of distended abdoman, generalized distention of the entire colon and very friable wall of recto-sigmoid colon making it unsuitable for ileoproctostomy. I am confident that this was a case of ulcerative colitis with early manifestations of toxic megacolon. The patient has to be followed up closely and will require sigmoidoscopy in the near future and if deemed necessary a decision for ileoproctostomy or abdominoperineal resection will be made at a later date. In emergency situation the perineal portion of the dissection in total colectomy is not a feasible operation because it requires a change of patient's position and perineal dissection with accompanied blood loss and should be done at a later date and the rectal stump should be closed.

DR. G. R. QURESHI *(Pathologist).* In the caecum the inner surface revealed prominant mucosal folds and irregular reddish area extending in the ascending colon. No ulceration seen. The thickness of the wall varied from 0.3 to 1 cm. In my opinion the patient was suffering from ischemic colitis because I was able to see thrombosed vessel in one of the slides of the splenic flexure of colon.