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Rectal Haematoma After Colonoscopy and Polypectomy. Presentation and Management

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1. Abstract

Mural haematoma after colonoscopy and polypectomy has been reported infrequently. We report a case of rectal haematoma that required prolonged hospitalization and surgical intervention. The literature on this complication is reviewed.

2. Case Report

A 55 year old woman was admitted as a day-procedure colonoscopy to investigate a positive faecal-occult blood test. Her history was a well woman with no medical co-morbidities. She had previous mid- urethral sling for bladder incontinence 18 years previously.

Colonoscopy revealed a polyp in the recto-sigmoid which was removed with cold snare resection. In recovery she complained of severe lower abdominal pain. After assessment by the endoscopist she was admitted to hospital for observation and analgesia and CT imaging was arranged to exclude perforation. Her blood pressure remained stable throughout. The CT images revealed a large peri-rectal haematoma. (Figure 1) Surgical consult was sought and in the absence of perforation and with no signs of peritonism and stable haemodynamics, non-operative treatment was advised.

Her haemaglobin had dropped from 13mg/dl to 9mg/dl

After several days of observation she was allowed home to be followed up in rooms. However 2 days after discharge she required re-admission for ongoing symptoms including pain, inability to evacuate adequately with passage of blood and mucus PR. Repeat imaging revealed minimal change to the size of the haematoma which was estimated to be 325ml. On digital examination a mass could be felt anteriorly.

Continued non-operative management was performed with minimal symptomatic improvement. After 12 days of in-hospital management, the patient and surgeon decided to to perform surgery to evacuate the haematoma. The possibility of full-thickness rectal injury and need for tempory stoma was discussed.

At laparoscopy the findings were swelling in the anterior rectal wall (Photo 1). An incision was made just proximal to the recto-vaginal fold and clot was evacuated. After irrigation a drain was inserted for ongoing clot evacuation. (Photo 2) Post surgery the patient reported symptomatic improvement although still had ongoing evacuation difficulties.

The patient was discharged home 8 days after surgery.

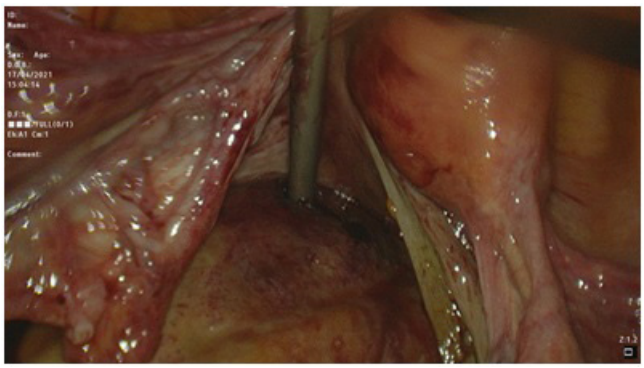

Photo 1

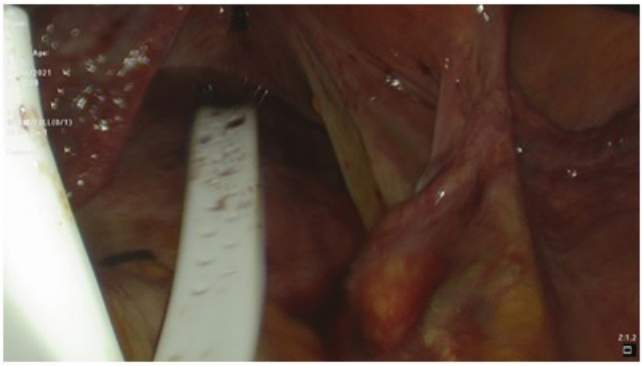

Photo 2

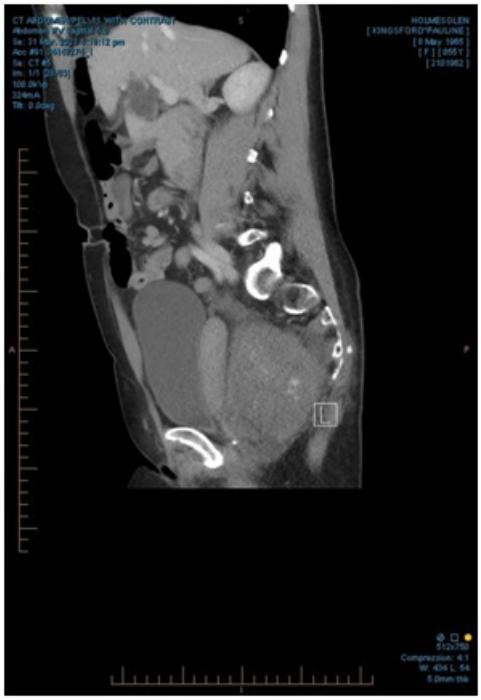

Figure 1: Sagittal CT image of abdomen and pelvis showing large rectal

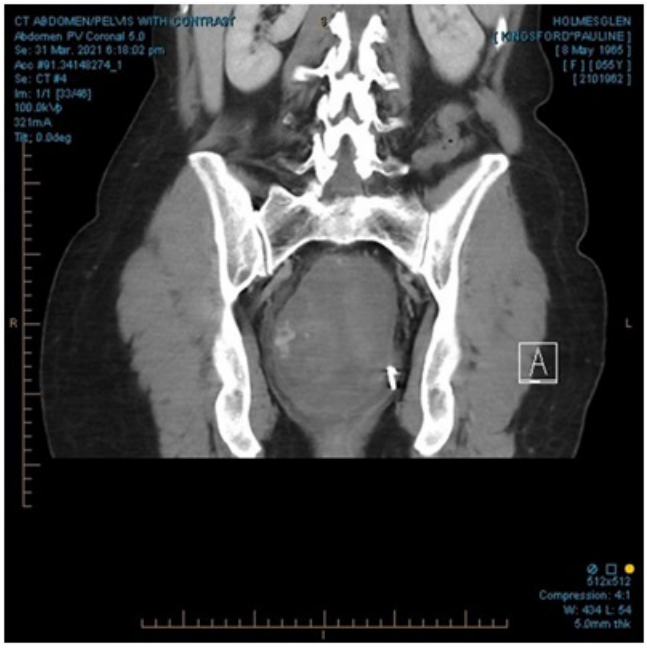

Figure 2: Coronal image of the rectal haematoma and endoscopic clip.

3. Discussion

The commonest and widely known complications of colonoscopy are perforation and bleeding. Frequency of complications during diagnostic colonoscopy remain relatively rare and range from 0.17%-0.4% [1].

Mural haematoma after colonoscopy is rare. Some cases presented in the literature are spontaneous haematomas in patients with co-agulation disorders or on anticoagulants [2]. Some cases are purely confined to the submucosa without affecting the muscle wall.

Our case was associatted with polypectomy and in a patient who was generally well with no coagulation disorder. The haematoma involved all layers of the rectal wall. (Figure 2-4) With increasing popularity of cold snare resection of polyps, this complication may however be increasing [3]. The case involved the rectum which has been reported after spot-marking before [4], but never related to polypectomy and with such a large haematoma.

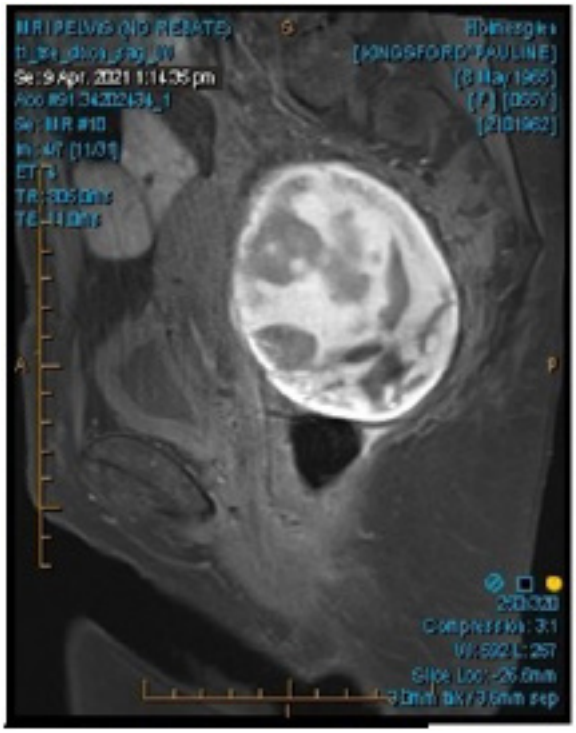

Figure 3: Siggital MRI view of rectal haematoma at day 9

Our case became difficult in management due to minimal resolu-tion of symptoms and minimal resolution of the haematoma on imaging despite prolonged hospitalization.

The decision for surgery came about due to these factors. The slow resolution of symptoms after surgery was felt due to the insinuat-ing nature of the haematoma through all layers of the wall of the rectum and the almost 360 degree parameter of the haematoma.

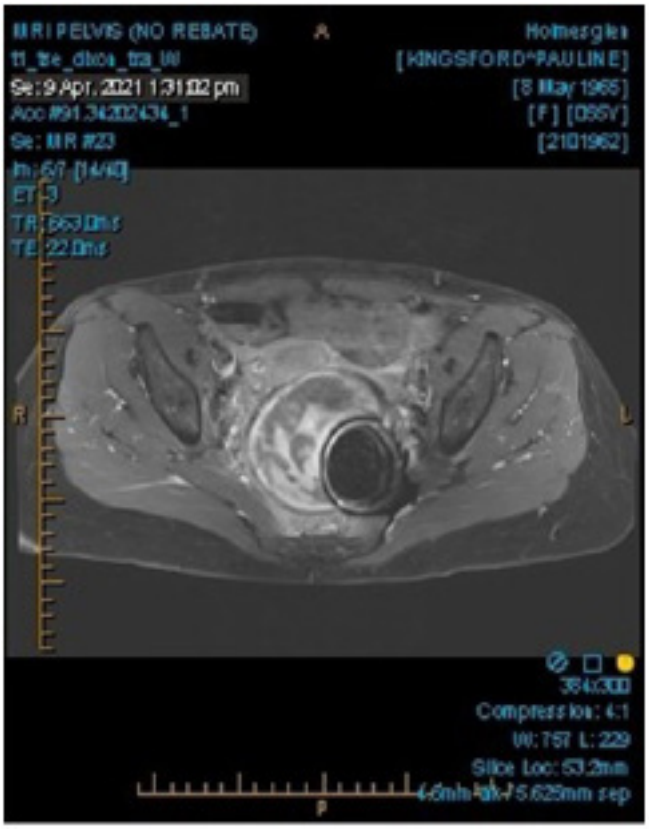

Figure 4: Cross sectional MRI view of rectal haematoma day 9.

Questions in management remain: could this haematoma have been decompressed early? Can the haematoma be controlled endoscopically in the early stages. Can a haematoma be observed immediately after polypectomy? The lady spent considerable time in hospital, and had a good outcome but the question remains whether earlier decompression of the haematoma would have led to a shorter hospital stay.

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