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Isolated Duodenal Varices Without Cirrhosis

Alexander Podboy¹, Patrick Kamath¹ and James Tabibian¹

Am J Gastroenterol 2016;111:454; doi:10.1038/ajg.2015.327

A 61-year-old man with a history of necrotizing pancreatitis requiring multiple necrosectomies and subsequent Roux-en-Y reconstruction presented with abdominal pain and fever. Endoscopic retrograde cholangiopancreatography revealed pyobilia and extensive circumferential isolated duodenal varices (a). There was no evidence of portohepatic venous thrombosis or cirrhosis on ultrasonography or computed tomography (b). Duodenal varices (arrows in b) are typically a result of cirrhotic portal hypertension, but in this patient they were deemed secondary to impaired superior mesenteric venous outflow related to prior surgery. The patient was placed on a noncardioselective β -blocker for variceal prophylaxis and has done well on follow-up.

¹Mayo Clinic, Rochester, Minnesota, USA.

A Prolapsing Pile Revealing Anal Squamous Cell Carcinoma

Fady Daniel¹, Viviane Trak-Smayra² and Nathalie Ziade¹

Am J Gastroenterol 2016;111:454; doi:10.1038/ajg.2015.307

A previously fit and well 69-year-old Caucasian woman presented with a 2-month history of defecation-related hematochezia that she attributed to a prolapsing hemorrhoid that required intermittent manual reduction. Proctologic examination in the knee–chest position revealed a prolapsed fungating ulcerated pseudopile (a). The patient was referred for surgical resection after undergoing pelvic magnetic resonance imaging and computed tomography of the chest and abdomen, which showed no signs of extra-anal dissemination. Pathology revealed moderately differentiated invasive squamous cell carcinoma of the anal canal, with an infiltrated resection margin (b). She was treated with 6 weeks of adjuvant radiation (30 Gy) plus 5-FU-cisplatin. Endoscopic examination performed 6 months later revealed scarring of the anal canal and no evidence of recurrence (c).

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