Title

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Isolated Duodenal Varices Without Cirrhosis

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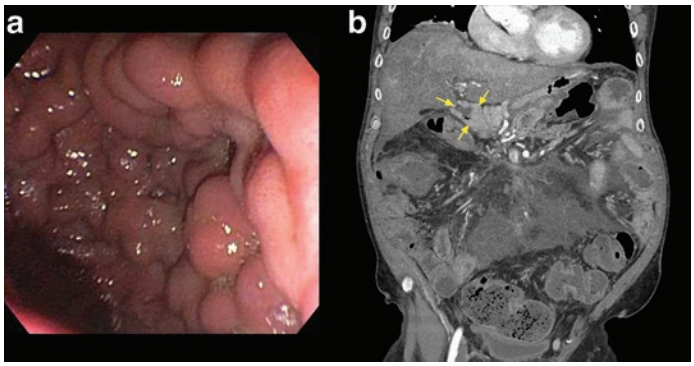

A 61-year-old man with a history of necrotizing pancreatitis requiring multiple necrosectomies and subsequent Roux-en-Y reconstruction presented with abdominal pain and fever. Endoscopic retrograde cholangiopancreatography revealed pyobilia and extensive circumferential isolated duodenal varices (**a**). 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.

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A Prolapsing Pile Revealing Anal Squamous Cell Carcinoma

Fady Daniel[1], Viviane Trak-Smayra[2] and Nathalie Ziade[1]

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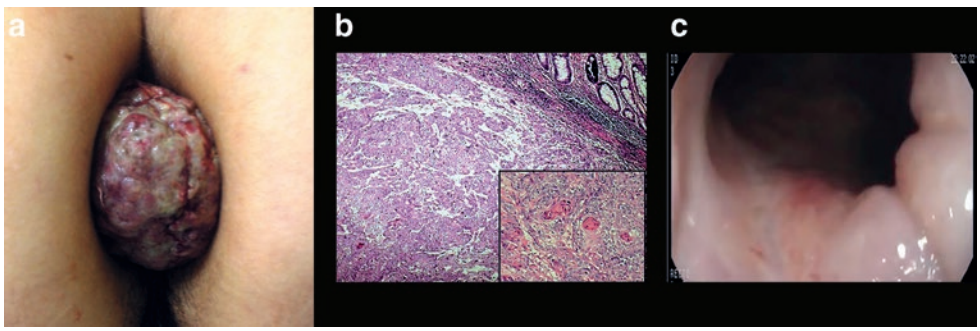

A previously fit and well 69-year-old Caucasian woman presented with a 2-month history of defecation-related hematochezia that she attributed to a prolapsing hemorrhoid that required intermittent manual reduction. Proctologic examination in the knee–chest position revealed a prolapsed fungating ulcerated 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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