

## Bleeding parastomal varices

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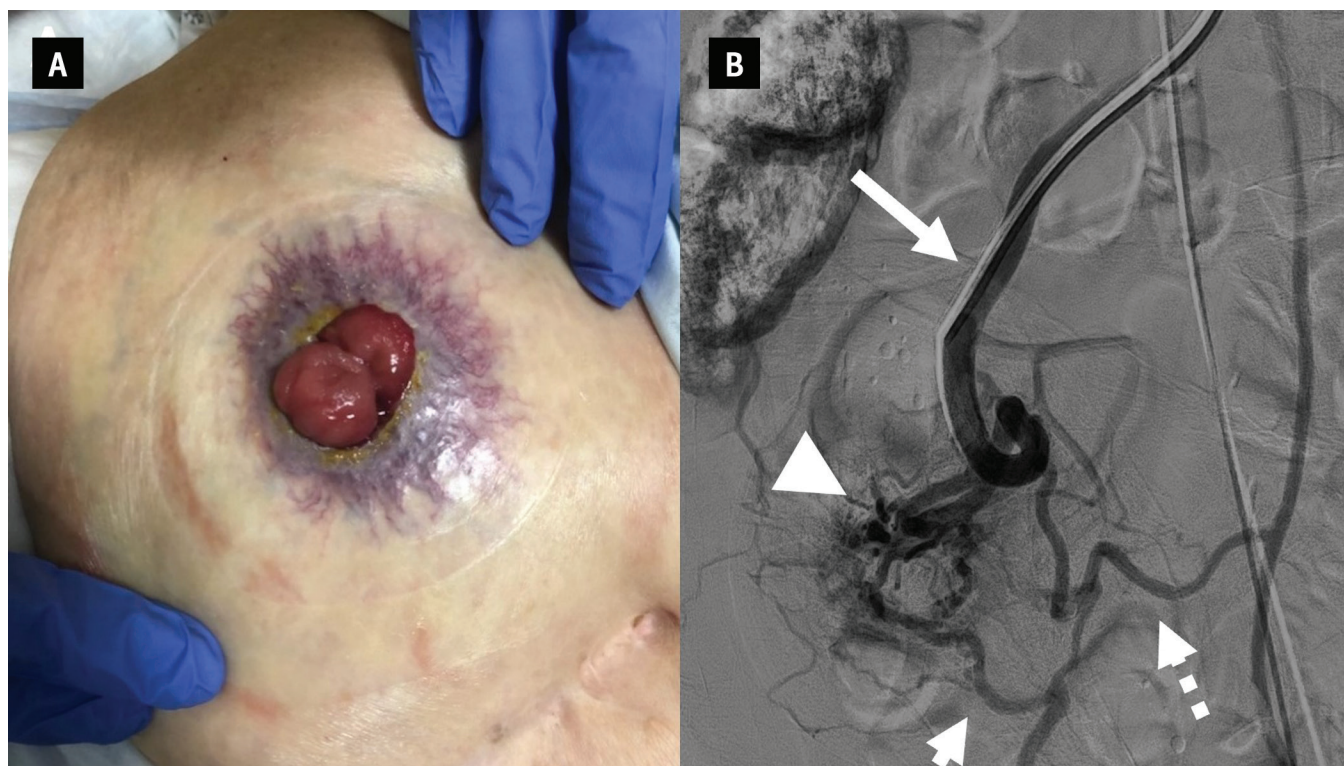
■ Cite as: *CMAJ* 2024 July 15;196:E879-80. doi: 10.1503/cmaj.231739

A 65-year-old woman was admitted to our hospital with presyncope resulting from profound anemia (hemoglobin 40 g/L; reference range 120–160 g/L). The patient had a history of rectal cancer, having undergone a low anterior resection with diverting loop ileostomy a year prior. Since then, she reported intermittent large-volume bleeding from her stoma. Outpatient and inpatient investigations, including an esophagogastroduodenoscopy, 2 ileoscopies, and a computed tomography (CT) angiogram, were normal. She had a history of biopsy-proven liver cirrhosis and, at the time of presentation, was staged at Child–Pugh class A.

After removing her stoma appliance, we found the characteristic appearance of parastomal varices: a circumferential bluish-purple subcutaneous ring around the stoma<sup>1</sup> (Figure 1A). A portal and superior mesenteric venogram confirmed the presence of parastomal varices with a rich collateral network between the superior mesenteric and inferior epigastric veins (Figure 1B).

The varices were successfully embolized by our interventional radiology service. The patient experienced no complications or further bleeding.

Parastomal varices are portosystemic venous shunts between a stoma and the abdominal wall.<sup>1,2</sup> The bowel is unaffected; therefore, endoscopy is generally normal. Since the classic signs are hidden by the stoma appliance, removing it is critical for diagnosis. Parastomal varices may affect as many as 5% of patients with stomas.<sup>2</sup> They are most commonly seen around ileostomies in patients with inflammatory bowel disease and primary sclerosing cholangitis,<sup>1</sup> but they can occur in any person with an ostomy and portal hypertension.<sup>1,2</sup> The diagnosis is best confirmed by venous phase angiography, mesenteric catheter venography, or duplex sonography.<sup>2</sup> As this is a venous pathology, CT angiogram will not show arterial extravasation and will commonly be reported as “normal.” Local measures of



**Figure 1:** (A) Loop ileostomy of a 65-year-old woman with parastomal varices showing characteristic parastomal skin changes. (B) Catheter venography showing retrograde flow of mesenteric vein (top arrow) supplying parastomal varices (arrowhead), with systemic venous shunt return (bottom, dashed arrows).

hemorrhage control, such as pressure, hemostatic agents, and suture ligation, can be used to temporize acute bleeding. The most effective long-term treatment is transjugular intrahepatic portosystemic shunting, although injection sclerotherapy and embolization can also be successful.<sup>1,3</sup> Avoiding stomas in high-risk patients, when possible, is ideal.<sup>1</sup>

## References

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**Competing interests:** None declared.

This article has been peer reviewed.

The authors have obtained patient consent.

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