

Letters

Profuse per rectal bleeding due to erosion of the inferior epigastric artery following a catheter tube caecostomy.

Editor,

We describe a case of profuse per rectal bleeding due to erosion of the right inferior epigastric artery, by a Foley catheter, used as a tube caecostomy, for decompression of underlying colonic pseudo-obstruction.

Case history: A sixty-four year old male was admitted to the intensive care unit with shortness of breath secondary to left ventricular failure, and chronic obstructive airways disease. He developed gross abdominal distension, which did not settle with conservative management. Imaging showed dilated loops of large bowel. Exploratory laparotomy revealed gross dilatation of the caecum and ascending colon. No mechanical cause of obstruction was evident. A 22 gauge Foley catheter was introduced through the base of the excised appendix, after decompression of the colon with a Savage's decompressor. The Foley catheter had been introduced into the peritoneal cavity through a prior stab incision in the anterior abdominal wall, overlying the right iliac fossa.

On the 9th post-operative day, the patient developed profuse fresh bleeding per rectum, associated with considerable bleeding into the caecostomy bag, from which he rapidly became shocked. Initial conservative management was abandoned in favour of a second laparotomy. Thorough examination of the colon revealed no palpable lesions. At the time of taking down the caecostomy, a copious bleed from the right inferior epigastric artery was detected, adjacent to the tract formed by the Foley catheter through the anterior abdominal wall. Following ligation of the vessel the patient's condition stabilised. No further rectal bleeding or discharge was recorded post-operatively.

Discussion: The management of pseudo-obstruction¹ is often conservative. Decompression can be accomplished by the passage of a sigmoidoscope and flatus tube, or colonoscopy. Benacci et al² conducted a review of patients at the Mayo clinic to determine the effectiveness of catheter tube caecostomy as a means of colonic decompression. They concluded that it was expeditious and safe, with acceptable morbidity in the majority of patients.

Gradual erosion of the right inferior epigastric artery by a caecostomy tube resulting in serious haemorrhage has not been previously documented. Computerised search of Medline and Pub Med databases did not reveal a single recorded case.

The inferior epigastric artery³ originates from the external iliac artery just superior to the inguinal ligament, runs superiorly in the transversalis fascia, and enters the rectus sheath below the arcuate line, lying deep to the rectus abdominis. It forms the lateral boundary of Hesselbach's triangle, which is bounded inferiorly by the inguinal ligament and medially by the rectus abdominis. Ideally any catheter brought out through the anterior abdominal wall should be sited lateral to the

Hesselbach's triangle, to prevent any deleterious effects to the inferior epigastric artery. In this case the Foley catheter used for the tube caecostomy had been impinging on the artery for nine days prior to eroding its wall. The resultant haemorrhage from the artery seems to have tracked down into the caecum, via the caecal-cutaneous fistula already formed by the catheter tube caecostomy. The haemorrhage, having gained access to the lumen of the large bowel, ultimately manifested as massive per rectal bleeding. Massive bleeds from a damaged inferior epigastric artery usually manifest as haematomas in the rectus abdominis muscle, but in this case the established caecal-cutaneous fistula appears to have diverted the blood into the caecal lumen.

Conclusion: This is the first documented case of severe haemorrhage associated with erosion of the right inferior epigastric artery by a tube caecostomy. Correct placement of the caecostomy tube lateral to Hesselbach's triangle should prevent this complication from occurring.

The Authors have no conflict of interest.

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1. Wegener M, Borsch G. Acute colonic pseudo-obstruction (Ogilvie's syndrome). Presentation of 14 of our own cases and analysis of 1027 cases reported in the literature. *Surg Endosc* 1987;**1**(3):169-74.
2. Benacci JC, Wolff BG. Caecostomy. Therapeutic indications and results. *Dis Colon Rectum*. 1995;**38**(5):530-4.
3. Moore KL, Dalley AF. Vessels of the anterolateral abdominal wall. In: Moore KL, Dalley AF, Editors. *Clinically oriented anatomy*. 4th ed. Canada; Lippincott Williams & Wilkins; 1999. p. 188-89.

Routine Rectal Biopsy?

Editor,

We describe a case of Non-Hodgkin's high grade B cell lymphoma of the rectum, which presented with a short history mimicking a perianal abscess. Careful examination under anaesthetic (EUA) and biopsies helped to clinch the diagnosis.

Case Report: A 76-year-old patient was admitted as an emergency with marked perianal pain for 1 week along with episodes of faecal incontinence during this period. The patient was being treated by the General Practitioner with antibiotics for suspected perianal infection.

On examination there was no induration around the anus but there was a point at which patient was maximally tender. The patient was examined by three senior clinicians, they all found different points of maximum tenderness. There was no obvious abscess. Investigations on admission including full blood picture, differential count, and inflammatory markers, were all within normal limits.