Acute colonic pseudo-obstruction should be suspected and excluded in patients with acromegaly presenting with delayed bowel movement with abdominal pain, and in such cases, gentle colonoscopic decompression should be considered.

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Diffuse cavernous hemangioma of the rectosigmoid colon

Rektosigmoid kolonda diffüz kavernöz hemanjiyoma

To the Editor,

Diffuse cavernous hemangioma of the rectosigmoid colon (DCHRC) is a rare disease that affects mainly young adults. Rectal bleeding (acute, recurrent or chronic) is the main symptom (1).

A 21-year-old male had been suffering from recurrent episodes of rectal bleeding for 17 years. His rectal bleeding had been attributed to hemorrhoids, and hemorrhoidectomy had been performed four times. Fecal incontinence was added to rectal bleeding in the last nine months. He was pale on his physical examination because of anemia. Rectosigmoidoscopy revealed mucosal dilated tortuous venous channels and angioectatic structures. Internal and external sphincter insufficiency was found by anorectal manometry. Magnetic resonance (MR) revealed wall thickening of the rectosigmoid region that was diffuse, circumferential and homogeneous, hypointense on T1-weighted images (WI), and hyperintense on T2WI (Figure 1). Perirectal fat was heterogeneous and contained hypointense serpiginous structures. The mass infiltrated the levator ani muscles and spread through the anal canal. Varicose and tortuous vessels were seen in the gluteal and right inguinal regions.

The clinical presentation of DCHRC is non-specific, and as a result, many patients are incorrectly diagnosed. DCHRC has been frequently mistaken for internal hemorrhoids, ulcerative colitis, or adenomatous polyp. Jeffery et al. (2) found that 80% of patients with DCHRC had had at least one surgical procedure performed because of an incorrect clinical diagnosis. Physicians should be alert to the presence of DCHRC in young patients who complain of rectal bleeding. Inflammation and

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Manuscript received: 20.02.2011 **Accepted:** 01.04.2011

doi: 10.4318/tjg.2012.0360

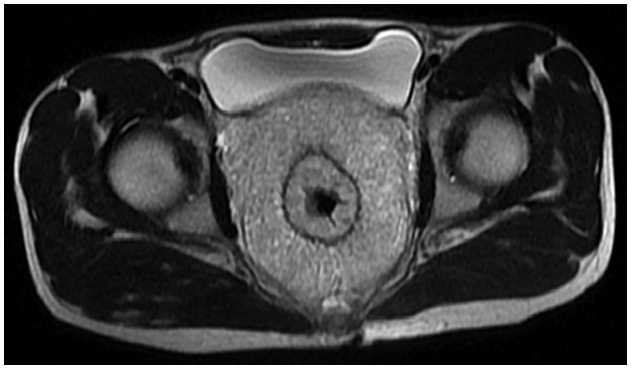

Figure 1. Axial T2-weighted image of the rectosigmoid colon wall and perirectal mass shows high signal intensity.

mucosal ulceration overlying the hemangioma usually cause the rectal bleeding (3). Massive hemorrhage is the major cause for the 50% mortality rate associated with this condition (4).

There are seven reports in the literature that describe the MR imaging findings (1,2). The MR imaging features of this disease are very characteristic, as there is no known disease that presents hyperintensity of the rectosigmoid wall and perirectal fat on the T2WI, as in this disease. Hemorrhoid should be considered in the differential diagnosis. Hemorrhoids usually involve only the anal region. Perirectal fat abnormalities and marked bowel wall thickening are not seen in hemorrhoids, and are easily shown by MR imaging. T2WI hyperintensity may be seen in severe inflammatory conditions such as Crohn's disease and ulcerative colitis. These diseases accompany significant colon wall enhancement.

Thus, computerized tomography and MR provide information about the border of the mass and relations to adjacent structures, which is necessary before surgical treatment. MR imaging findings of diffuse cavernous hemangioma of the rectosigmoid colon are reliable, specific, and valuable in the diagnosis.

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Rabeprazole-induced acute cholestatic liver injury

Rabeprazolün indüklediği akut kolestatik karaciğer hasarı

To the Editor,

Proton pump inhibitors are widely used drugs in the treatment of peptic ulcer and gastroesophageal reflux disease (GERD). In addition to their well-documented efficacy, these drugs are generally well tolerated. There are only a few case reports concerning omeprazole-, pantoprazole- and lansoprazole-related hepatotoxicity (1). There is also only one report in the English literature about rabeprazole-associated hepatotoxicity (2). Herein, we present a new case of rabeprazole-induced acute hepatotoxicity.

A 46-year-old male was admitted to the gastroen-

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Manuscript received: 20.02.2011 **Accepted:** 10.06.2011

doi: 10.4318/tjg.2012.0365