Drastic times call for skilful measures!

Zor durumlar maharetli önlemler gerektirir!

To the Editor

A 47-year-old lady, a known hypertensive and diabetic with a large anterior abdominal wall hernia, presented with recurrent passage of fresh blood per rectum. A colonoscopy revealed an actively oozing giant sigmoid diverticulum (Figure-1A). The patient being a poor surgical candidate was taken up for transcatheter embolization. A digital subtraction angiogram confirmed the presence of a tortuous vessel supplying the diverticulum which was coil embolized (Figure-1B) and a subsequent follow-up angiogram revealed no distal flow (Figure-2A). The coiling was effective, showed instant control of bleeding without any early or delayed complication. Follow-up CT (Figure-2B) and colonoscopy revealed no bleeding or ulceration. The patient remains well 1 year post treatment.

Colonic diverticulum is considered giant when its size reaches over 4 cm in the greatest dimension. The sigmoid colon (93%) is the commonest site, chiefly along its mesenteric border at the site of penetrating blood vessels (1). Histologically, giant colonic diverticula can be categorized into inflammatory type (66%), pseudodiverticula (22%), and true diverticula (12%) (2). The most frequent complications of a giant diverticulum are diverticulitis, pericolonic abscess, perforation, bleeding and diverticular volvulus. Bleeding, if present, is usually self-limiting although excessive life-threatening hemorrhage has been reported in 3-5% cases. Transcatheter arteriography and intervention in the form of superselective embolization has emerged as a safe, effective and durable alternative to an emergency surgery for the treatment of bleeding colonic diverticula especially in the high-risk patient population (3-5). Tan et al. have emphasized it as the first-line treatment if possible and available (3). Embolization can result in definitive treatment (in up to 50-63% of patients) and in addition can act as a bridge to a subsequent more definitive elective surgery (3, 4). Conventionally, segmental

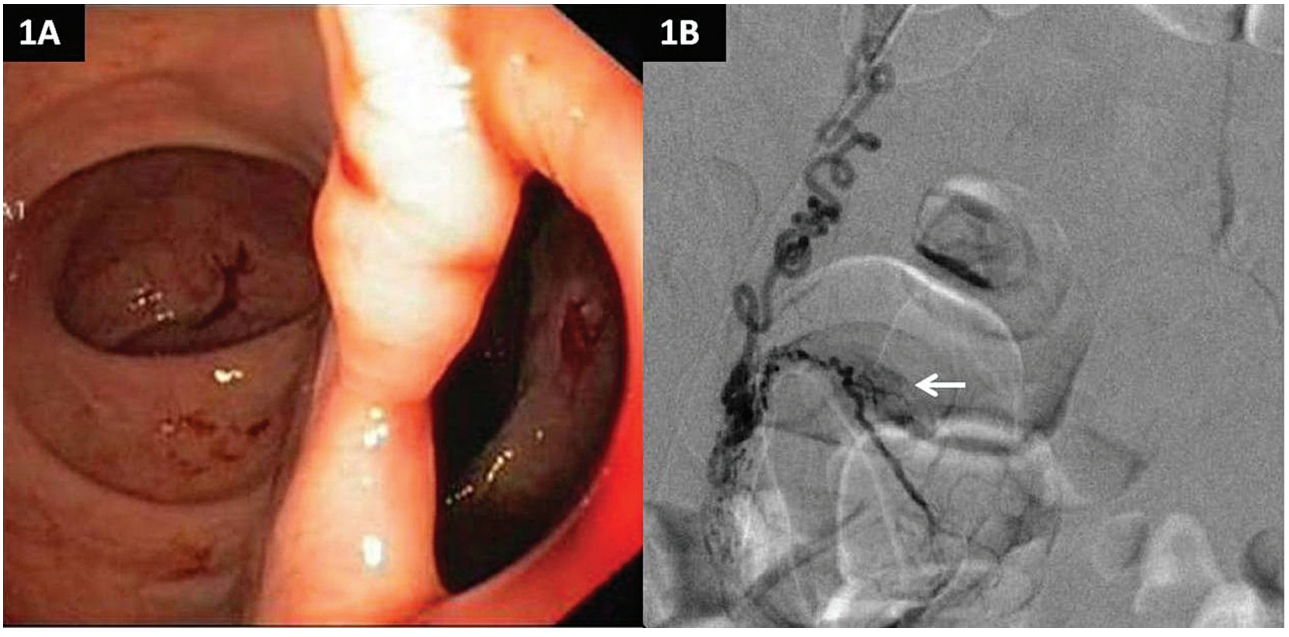

Figure 1. Actively oozing giant sigmoid diverticulum on colonoscopy **(A)** and on digital substraction angiography **(B).**

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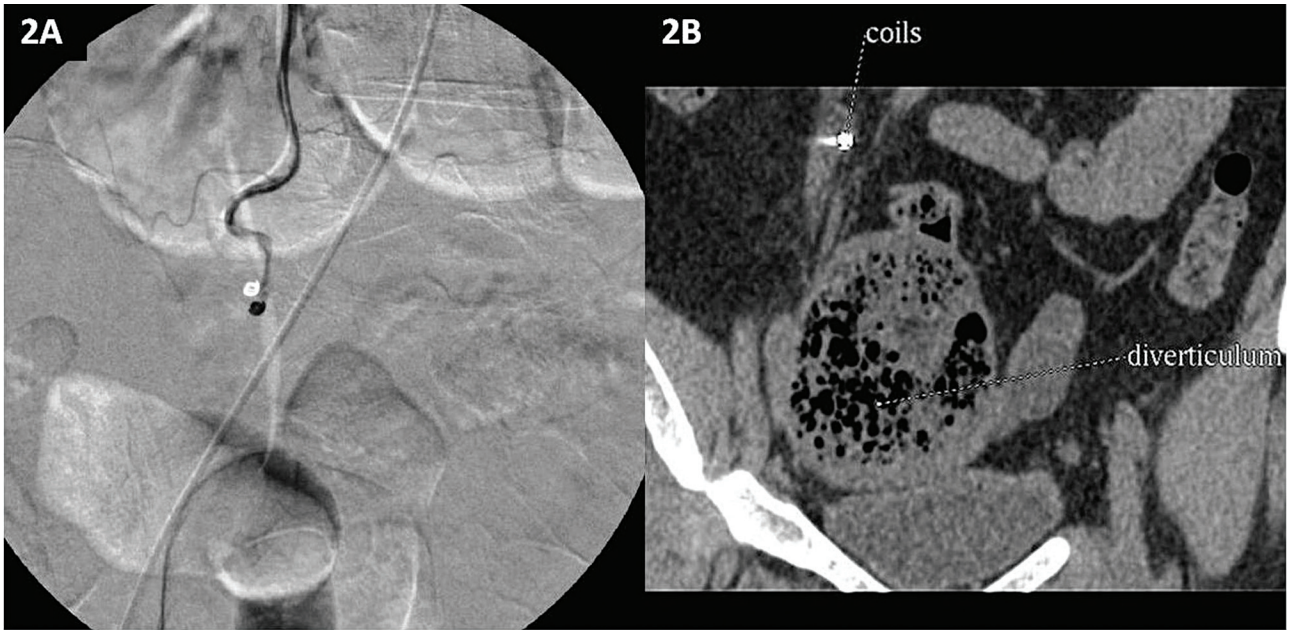

Figure 2. (A) Digital substraction angiography shows no distal flow. **(B)** Computed tomography scan of abdomen shows coils and sigmoid diverticulum.

resection of the involved colon with primary anastomosis is considered the definitive treatment of choice (2). Even when surgery is being contemplated, the procedure still remains extremely valuable as it allows sufficient patient resuscitation and optimal preoperative preparation and patient stabilization prior to the surgery. Pre-operative embolization can also limit the extent of resection (3). Amongst various agents used for colonic embolization, microcoils are the most preferred. They reduce the perfusion pressure whilst allowing sufficient collateral circulation to avert bowel infarction (5).

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