Medical Memoranda

Multiple Gastrointestinal Haemangiomata

British Medical Journal, 1970, 4, 600

Haemangiomata of the intestine are rare, and in most reported series account for only 0·05% of all gastrointestinal neoplasms (Raiford, 1932; Merchant, 1939; Pearce *et al.*, 1954).

The present case was first documented by Heycock and Dickinson (1951), when 30 separate haemangiomata were removed from the small intestine. Initially the patient did well, but 17 years later persistent gastrointestinal haemorrhage necessitated further laparotomy, and another 38 haemangiomata were excised from the gastrointestinal tract.

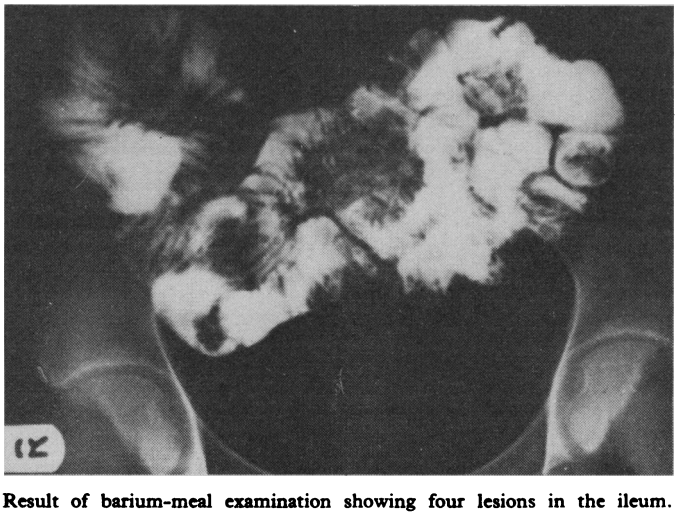
Case History

A woman born in 1944 was noted at birth to have supernumerary toes and a lump on the posterior aspect of the left side of the chest which, when excised 16 months later, proved to be a cavernous lymphangioma. In March 1950 she was admitted to hospital with melaena and was found to have a microcytic hypochromic anaemia and a haemoglobin of 37%. As several investigations failed to reveal the source of haemorrhage a laparotomy was performed, and 30 separate haemangiomata were removed from the small intestine through multiple enterotomy incisions (Heycock and Dickinson, 1951). Subsequently though her attendance record at school was good she was unable to participate in any sporting activities because of recurrent bouts of anaemia and had to take regular oral iron supplements.

In 1967 she was admitted to University College Hospital for excision of another haemangioma (13 by 12 by 2 cm.) from the left posterior aspect of the chest. At this time it was noted that her haemoglobin was 60% and that several stool specimens were strongly positive for occult blood. Later that year, while resident in Canada, she had a large melaena, and in spite of receiving six units of blood her haemoglobin two weeks later was still less than 50%.

In September 1968 she was referred back to University College Hospital when, after another severe bout of melaena, she became dyspnoeic and had severe and persistent palpitations; her haemoglobin was then only 35%. Examination on her admission showed a regular pulse of 90 beats/min. and an enlarged spleen, palpable some 3 cm. below the left costal margin. On her neck there was a small superficial haemangioma, over the left scapula there was a similar lesion, and positioned deeply in her right arm another haemangioma was evident. In addition there were several small lesions on the soles of her feet.

Barium studies undertaken a short while earlier at St. Helier Hospital, Carshalton, showed a filling defect in the pyloric antrum, four lesions in the ileum (see Fig.), and two further lesions in the large intestine—one in the transverse colon and another in the descending colon. In addition, calcification in the right hypochondrium was noted.



Result of barium-meal examination showing four lesions in the ileum.

After preoperative blood transfusion a laparotomy was performed and 38 haemangiomata were removed from the gastrointestinal tract. Though the majority were small and were found in the jejunum, both the most proximal lesion in the pyloric antrum and the distal lesions in the colon had attained a considerable size. Apart from two small lesions in the pancreas there were no other haemangiomata within the abdomen. Though the spleen was enlarged there was no macroscopic evidence that it contained haemangiomata.

Her postoperative recovery was rapid and uneventful, and when seen one year later in the outpatient clinic her haemoglobin was 98% and maintained without oral iron supplements.

Histologically the specimens showed numerous cavernous haemangiomata measuring 0·5-2 cm. positioned in the submucosa of both the small and large intestines.

Comment

Since the original description by Gascoyen (1860) of a haemangioma of the intestine there have been several reports of both single and multiple haemangiomata arising in most parts of the gastrointestinal tract.

It is generally believed that angiomata are congenital. They pursue a benign course and if untreated grow pari passu with the child until adult life. Preoperative diagnosis is often difficult and rests clinically on three main features. Firstly, the presence of any associated lesions in the skin or mucous membranes, as seen in this case; secondly, a family history, which we could not elicit; and thirdly, a high degree of suspicion.

Radiology is perhaps the most useful investigation if it shows ectopic calcification within the haemangioma, but direct evidence of a filling defect on barium studies is not always available, and circumstantial evidence such as a localized narrowing of the bowel lumen or occasionally areas of regional dilatation may be all that can be shown. The present case illustrates some of these problems; for whereas the tumours in the stomach and colon were readily identified, those in the small intestine were more difficult to define. The only lesions shown radiologically were those in the ileum (see Fig.), whereas at operation most of the tumours were found in the jejunum.

The present case shows that haemangiomata of the intestine can lead to severe and debilitating symptoms but that the condition is amenable to surgery.

We wish to thank Mr. David Matthews and Professor C. G. Clark, University College Hospital Medical School, for permission to report this case.

NEIL MCINTOSH, M.B., B.SC.,
Formerly House Surgeon.

J. HARRIS, M.B., B.SC., F.R.C.S.,
Lecturer in Surgery.
University College Hospital Medical School, London, W.C.1.

References

Gascoyen (1860). *Transactions of the Pathological Society of London*, **11**, 267.
Heycock, J. B., and Dickinson, P. H. (1951). *British Medical Journal*, **1**, 620.
Merchant, F. T. (1939). *Archives of Surgery*, **39**, 1031.
Pearce, A. E., Ivker, M., and Oller, S. (1954). *Surgery*, **36**, 299.
Raiford, T. S. (1932). *Archives of Surgery*, **25**, 122.