

## **Vesical Varices Secondary to Portal Hypertension**

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*To the Editor:* Portal hypertension is a frequent consequence of cirrhosis and may promote development of dilated venous collaterals or varices. Most frequent varices in portal hypertension develop at the lower esophagus, and may be complicated by rupture and hemorrhage. Intestinal ectopic varices are seldom described in other parts of the digestive tract (1). Extra-intestinal ectopic varices are very rare. We recently treated a cirrhotic patient who presented with gross hematuria due to vesical varices.

A 54-year-old woman was referred to the emergency unit with a sudden onset of profuse gross hematuria. She was suffering from active chronic alcohol abuse complicated by liver cirrhosis and chronic pancreatitis. Cirrhosis has been symptomatic with episodes of decompensated ascites and ruptures of esophageal varices. These varices had been controlled by sclerotherapy and band ligation. Surgical past history also revealed cholecystectomy with common duct derivation, radical left nephrectomy for renal cell carcinoma, and hysterectomy. At admission, hematuria had stopped. Abdominal ultrasound showed multiple non echogenic nodes in the superior and posterior wall of the bladder. Cystoscopy demonstrated large vesical varices (Fig 1). Selective angiography of the superior mesenteric artery showed early demonstration of venous dilatations situated at the mesentery root, in the ileal and colonic region, draining to large vesical varices and then to the right intern and extern iliac veins.

Propanolol treatment was initiated. No hematuria recurrence was reported at one-year follow-up.

Vesical varices secondary to portal hypertension are very rare, as the bladder wall is an unusual collateral route for the venous splanchnic blood. In most cases, varices secondary to portal hypertension are located in the lower esophagus, in the stomach or in the rectum, and rarely in other part of the digestive tract (1). Vesical varices may appear when usual splanchnic bed collaterals can not develop, mainly due to previous medical intervention (2). In the case described above, the patient experienced complicated esophageal varices treated by sclerotherapy and band ligation. Moreover, she underwent abdominal surgical procedures that may have interrupted some portal vein collaterality. In this setting, splanchnic blood found its way back to the general circulation through the bladder venous system. In these rare cases of hematuria secondary to portal hypertension, therapy should be extrapolated from the management of the esophageal varices. This case suggests that non-selective beta blockers should be the first line therapy in the prevention of recurrent hemorrhage from ectopic vesical varices, as it was demonstrated in esophageal varices (3,4).

## References

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**Figure Legend**

Cystoscopic examination demonstrating varices on the posterior wall of the bladder.