MedCrave
Step into the World of Research

Obstetrics & Gynecology International Journal

Case Report

Open Access

CrossMark

Tubular adenoma as a rare cause of hematochezia in pregnancy: a case report and review of diagnostic approach

Abstract

Rectal bleeding (hematochezia) is common in pregnancy, often due to benign causes like hemorrhoids, but serious etiologies can threaten maternal and fetal health. We report a 34-year-old G1P0 woman at 25w0d, admitted for symptomatic anemia after recurrent, large-volume hematochezia requiring multiple transfusions. Initial colonoscopy revealed blood clots without active bleeding, but a repeat procedure identified a bleeding 15mm sessile tubular adenoma in the colon. The patient underwent resection of the polyp and clip placement to control and prevent future episodes of hematochezia allowing her to continue without any further complications in her pregnancy. This case underscores the need to consider neoplastic causes in pregnant patients with persistent hematochezia, despite the rarity of such findings.

Keywords: rectal bleeding, pregnancy, tubular adenoma, pregnancy complication, hematochezia, colonoscopy, anemia

Volume 16 Issue 5 - 2025

Andreina Colatosti Catanho DO, Jordan Hoke MD, Neil Patel MD

Department of Obstetrics and Gynecology, The Brooklyn Hospital Center, 121 Dekalb Ave. Bk, NY, 11201, USA.

Correspondence: Neil Patel MD, Department of Obstetrics and Gynecology, The Brooklyn Hospital Center, 121 Dekalb Ave. Bk, NY, 11201, USA, Tel 303-919-7668

Received: October 09, 2025 | **Published:** October 31, 2025

Introduction

Rectal bleeding (hematochezia) in pregnancy is a common symptom occurring in up to 40% of pregnant women. The frequency of anorectal symptoms appears to increase throughout pregnancy, with highest reported incidences in the third trimester. Exacerbation of pre-pregnancy benign conditions such as anal fissures and hemorrhoids can occur due to the physiologic changes of pregnancy, as well as the anatomical effects of the expanding gravid uterus.

Evaluation of rectal bleeding in pregnant patients should focus on excluding serious causes, such as neoplastic and inflammatory conditions, which may present with similar symptoms as benign conditions but carries significant maternal and fetal risks. Due to the trend of advancing maternal age continuing as women are increasingly deferring childbirth, neoplastic conditions identified during pregnancy are increasing, and thus colorectal malignancy should not be overlooked.

Differential diagnosis of rectal bleeding in pregnancy can include hemorrhoids, anal fissures, infectious diarrhea, inflammatory and irritable bowel disease, sexually transmitted proctitis, diverticular disease, and colorectal neoplasms. A thorough medical history to determine the characteristics of the bleeding is essential, with specific attention to onset, frequency, volume, and associated symptoms. Similar to the non-pregnant population, identification of 'red-flag' symptoms such as unexplained weight loss, altered bowel habits, significant or acute anemia, abdominal pain and a family history of bowel cancer should prompt clinicians to consider more insidious etiologies of rectal bleeding in pregnant patients.

In addition to a thorough physical examination, initial assessment should include a full blood count with iron studies and C-reactive protein for evaluation of anemia or acute inflammation. Additional studies including fecal calprotectin, a non-specific biomarker of gastrointestinal inflammation which levels do not rise during pregnancy, and stool culture can be considered when clinically appropriate if available.

Flexible sigmoidoscopy is often necessary to establish the diagnosis and exclude other causes of lower gastrointestinal bleeding. Evidence regarding the concerns about the fetal and maternal harms of bowel preparation, endoscopic intubation, or cardiac events is limited; however, several systematic reviews of pregnant women undergoing gastrointestinal endoscopy for any indication support the safety and utility of endoscopy in pregnancy.. Thus, endoscopy should not be withheld on the basis of pregnancy when clinically indicated. Imaging modalities such as MRI and ultrasound can be useful if inflammatory bowel disease is suspected. Due to concerns regarding the safety of gadolinium contrast in pregnancy, non-enhanced MRI is preferred in pregnancy.

Treatment of rectal bleeding should be diagnosis specific, with the ultimate goal of mitigation and prevention of serious significant adverse pregnancy outcomes. Immediate management should focus on maternal stabilization, followed by determination of appropriate long-term management to optimize outcomes.

Case presentation

A previously healthy 34-year-old woman, gravida 1, para 0 at 25 weeks and 0 days gestation, presented to the hospital via EMS with chief complaint of syncopal episode following large-volume hematochezia. On arrival, the patient reported a single same-day large episode of hematochezia while using the bathroom followed by a syncopal episode. On initial presentation, she was alert and oriented, and had complete recollection of prior events. Additionally, she reported dizziness, palpitations, malaise, nausea and one episode of nonbilious non bloody emesis. She denied any abdominal or head trauma or any additional obstetrical complications during her prenatal course. Although she denied similar past episodes, patient did endorse mild infrequent bloody stools at the beginning of pregnancy; however, denied medical workup for past episodes. She denied any other past or current gastrointestinal complaints or any history of diagnosed gastrointestinal conditions or history of colorectal cancer. Patient also denied any obstetrical complaints, no leakage of fluid, vaginal bleeding, abdominal pain or contractions. Bedside ultrasound showed

fetus in breech presentation and a posterior intact appearing placenta. Biophysical profile of 8/8 with a reactive and reassuring non-stress test.

Initial labs were remarkable for hemoglobin of 4.8g/dL and hematocrit of 15%. Transfusion pRBCs was immediately started. Obstetrical physical exam was unremarkable, a digital rectal examination was performed which was significant for dried clotted perianal blood. There were no hemorrhoids, perianal fissures, or active rectal or vaginal bleeding identified.

Throughout the patient's hospital stay, she reported sporadic episodes of loose dark tarry bowel movements with visible blood clots in toilet and tissue paper. Patient noted to have significant symptomatic anemia and ultimately received a total of nine units of packed red blood cells, one unit of fresh frozen plasma, and one unit of packed apheresis platelets.

A gastroenterology consult was placed due to concern for gastrointestinal pathology. Following consultant recommendations, patient underwent colonoscopy and esophagogastroduodenoscopy.

Operative findings

On hospital day 3, patient underwent a colonoscopy under sedation but preparation of the colon was inadequate. It was presumed that the source of bleeding was from the upper GI tract. The following day, the patient underwent a repeat procedure under general anesthesia with both upper gastrointestinal endoscopy and colonoscopy to investigate ongoing bleeding. Upper endoscopy revealed a normal esophagus, stomach, and duodenum, including the examined portion of the jejunum, with no evidence of active bleeding or significant pathology, though yellowish bilious fluid was noted. Colonoscopy showed extensive hematin and old blood throughout the colon and ileum, but no active bleeding source, diverticula, or masses were identified. Despite copious lavage, visualization remained limited. Given the negative findings from both procedures, a mid to distal small bowel source of bleeding was suspected. Transfer to a tertiary care center for further evaluation was initiated

Once care was established at the tertiary care center, she underwent a second upper GI endoscopy, colonoscopy, and video capsule enteroscopy. Repeat procedures revealed esophageal mucosal changes suggestive of eosinophilic esophagitis, but no biopsies were taken; the stomach and duodenum appeared normal with no evidence of bleeding. During capsule endoscopy, a 15 mm sessile polyp in the ascending colon was identified, resected using injection-lift and hot snare technique, and treated with bipolar cautery and clip placement. Although the polyp exhibited oozing, it was not believed to account for the severity of bleeding and transfusion needs. The remainder of the colon and terminal ileum appeared normal. Concurrently the endoscopy also revealed scattered small bowel erosions, aphthae, non-bleeding polypoid lesions, and a possible non-bleeding diverticulum, without evidence of frank bleeding. Subsequent surgical pathology of the resected polyp confirmed it as a tubular adenoma, a benign neoplastic lesion.

Discussion

Rectal bleeding during pregnancy, while frequently attributed to benign anorectal conditions such as hemorrhoids or fissures, must be carefully evaluated when bleeding is significant or recurrent. This case demonstrates a rare and clinically significant cause of hematochezia in a pregnant patient: a bleeding sessile tubular adenoma of the ascending colon. The patient presented with symptomatic anemia, requiring substantial blood transfusion support, highlighting the potential severity of such presentation.

Neoplastic etiologies of gastrointestinal bleeding in pregnancy are uncommon, but the incidence may rise in parallel with increasing maternal age and delayed childbearing. Tubular adenomas are premalignant lesions that carry a risk of progression to colorectal carcinoma if undetected or untreated. Although most are asymptomatic, larger adenomas can ulcerate and bleed. This case emphasizes the importance of including neoplastic conditions in the differential diagnosis, especially when the clinical presentation involves large-volume bleeding or anemia unresponsive to initial conservative management.

This case is unique in that the patient, a healthy 25-year-old in her first pregnancy, presented at 25 weeks gestation with painless rectal bleeding and no prior gastrointestinal symptoms or family history suggestive of hereditary polyposis syndromes. Her pregnancy had been uncomplicated up to that point without any risk factors. Initial evaluation ruled out obstetric and lower GI sources of bleeding, prompting further investigation. Video capsule enteroscopy played a pivotal role in this case. While its use during pregnancy is not routine and typically reserved for select cases; it provided a safe and effective means of visualizing the small intestine without radiation or anesthesia. The capsule identified a bleeding polyp, which was subsequently resected surgically.

There is limited literature on the management of small intestinal polyps in pregnancy, with only a few cases reporting similar findings. Most emphasize the importance of individualized care, balancing maternal and fetal safety with the need for accurate diagnosis and timely treatment. This case highlights the feasibility and value of capsule endoscopy in selected pregnant patients, particularly when conventional endoscopic evaluation is inconclusive or contraindicated.

Importantly, the case underscores the need for a multidisciplinary approach. Collaboration between obstetrics, maternal fetal medicine, anesthesiology and gastroenterology was critical in guiding diagnostic decisions, ensuring maternal stabilization, and minimizing fetal risk. It also reinforces the importance of maintaining a broad differential diagnosis in pregnant patients with GI symptoms, especially when initial findings are atypical or non-diagnostic.[1–15]

Conclusion

This case highlights the importance of considering gastrointestinal sources of bleeding during pregnancy, even in the second trimester when obstetric causes are often prioritized. The identification of a bleeding sessile tubular adenoma in the colon via video capsule enteroscopy underscores the utility of noninvasive diagnostic modalities in pregnant patients. Timely surgical intervention and supportive care led to a favorable maternal outcome. Clinicians should maintain a broad differential diagnosis when evaluating rectal bleeding in pregnancy to ensure rare but significant causes are not overlooked.

This case emphasizes the need for heightened awareness of uncommon GI pathologies as potential sources of rectal bleeding in pregnancy. Early recognition, appropriate diagnostic strategies, and collaborative management are key to ensuring favorable outcomes for both mother and fetus.

Acknowledgments

None.

Funding

None.

Conflicts of interest

The author declares that there is no conflict of interest.

References

1. Riss S, Weiser FA, Schwameis K, et al. The prevalence of hemorrhoids in adults. *Int J Colorectal Dis*. 2012;27(2):215–220.
2. Staroselsky A, Nava-Ocampo AA, Vohra S, et al. Hemorrhoids in pregnancy. *Can Fam Physician*. 2008;54(2):189–190.
3. Poskus T, Buzinskienė D, Drasutiene G, et al. Haemorrhoids and anal fissures during pregnancy and after childbirth: a prospective cohort study. *BJOG*. 2014;121(13):1666–1671.
4. Ferdinande K, Dorreman Y, Roelens K, et al. Anorectal symptoms during pregnancy and postpartum: a prospective cohort study. *Colorectal Dis*. 2018;20(12):1109–1116.
5. Poston GJ, Tait D, O'Connell S, et al. Diagnosis and management of colorectal cancer: summary of NICE guidance. *BMJ*. 2011;343:d6751.
6. Story L, Rafique S, Samadi N, et al. Lower gastrointestinal bleeding in pregnancy: Differential diagnosis, assessment and management. *Obstet Med*. 2021;14(3):129–134.
7. Koslowsky B, Grisaru-Granovsky S, Livovsky DM, et al. Pregnancy-onset inflammatory bowel disease: a subtle diagnosis. *Inflamm Bowel Dis*. 2018;24(8):1826–1832.
8. Gausman V, Dornblaser D, Anand S, et al. Risk factors associated with early-onset colorectal cancer. *Clin Gastroenterol Hepatol*. 2020;18(12):2752–2759.e2.
9. Zachariah SK, Fenn MG. Acute intestinal obstruction complicating pregnancy: diagnosis and surgical management. *BMJ Case Rep*. 2014;2014:bcr2013203235.
10. Saravanane C, Robinson Smile S, Chandra SS, et al. Rectal bleeding: a rare complication of abdominal pregnancy. *Aust N Z J Obstet Gynaecol*. 1997;37(1):124–125.
11. Flanagan E, Wright EK, Begun J, et al. Monitoring inflammatory bowel disease in pregnancy using gastrointestinal ultrasonography. *J Crohns Colitis*. 2020;14(10):1405–1412.
12. Cappell MS, Fox SR, Gorrepati N. Safety and efficacy of colonoscopy during pregnancy: an analysis of pregnancy outcome in 20 patients. *J Reprod Med*. 2010;55(3-4):115–123.
13. American College of Radiology. ACR–SPR practice parameter for imaging pregnant or potentially pregnant adolescents and women with ionizing radiation. 2018.
14. Mahadevan U, Robinson C, Bernasko N, et al. Inflammatory bowel disease in pregnancy clinical care pathway: a report from the American Gastroenterological Association IBD parenthood project working group. *Gastroenterology*. 2019;156(5):1508–1524.
15. Saif MW. Management of colorectal cancer in pregnancy: a multimodality approach. *Clin Colorectal Cancer*. 2005;5(4):247–256.