A Rare Case of Concomitant Bleeding from a Dieulafoy's Lesion and a Gastro-esophageal Varix type 1 in a Decompensated Cirrhotic Patient.

Nghia Nguyen DO[1], Prateek S. Harne[1], Murthy Badiga MD[1], Asif Zamir MD[1]
[1]Division of Gastroenterology, University of Texas Rio Grande Valley School of Medicine-Doctors Hospital at Renaissance; Edinburg, Texas

INTRODUCTION

Bleeding from Dieulafoy's lesion (DL) is an important cause of gastrointestinal bleed (GIB) with relatively high mortality. Their incidence is reported to be 1% to 2% of all GIBs. DLs are most often linked to cardiopulmonary and renal disease. Bleeding gastro-esophageal varices (GOV) type 1 also pose a high mortality rate (30%). We present a rare case of simultaneous bleeding from an antral DL and a GOV type 1 in a decompensated cirrhotic patient.

CASE DESCRIPTION

A 57-year-old man with a history of decompensated liver cirrhosis complicated by esophageal varices presented with multiple episodes of hematemesis. He denied diarrhea or bloody stool. As per outside records, his most recent EGD 7 months prior was notable for bleeding esophageal varices requiring 3 band ligations. Patient was tachycardic on presentation. Initial labs showed WBC 17.3, Hb 10.7, Hct 34, platelet 166, INR 1.90, Na 132, Cr 0.9, AST 39, ALT 20, ALP 129, total bilirubin 2.9. The patient received blood transfusion and was started on octreotide and pantoprazole infusions. Subsequent EGD revealed a bleeding GOV type 1 treated with three band ligations and interestingly, also a bleeding antral DL which was treated with 3cc epinephrine injection followed by application of three hemoclips. The patient's clinical status improved with complete resolution of GIB.

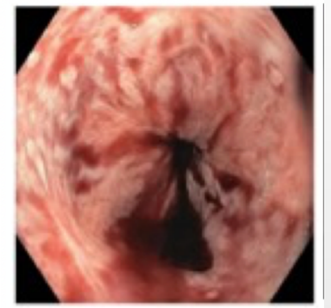

Figure (a)

Figure a – Large amounts of blood noted in the fundus

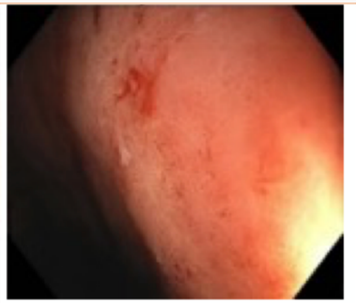

Figure (b)

Figure b – Antral Dieulafoy's lesion

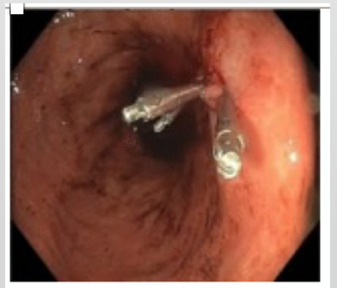

Figure (c)

Figure c – Dieulafoy's lesion status post banding and epinephrine injection

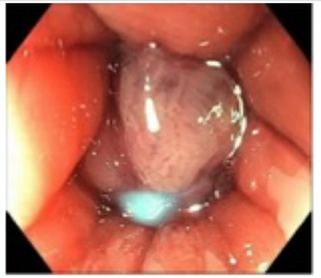

Figure (d)

Figure d – Gastric varix status post banding and epinephrine injection

DISCUSSION

DL is a rare cause of GIB in advanced liver disease (ALD), which is not directly related to portal hypertension. It is an abnormally large and tortuous submucosal artery that can rupture and cause life-threatening GIB. With the shift from surgical treatment toward endoscopic interventions, the mortality and morbidity of DLs reportedly improve from 80% to 8.6%, although, a combined mortality rate from a bleeding DL and GOV remains very high. Endoscopic therapies include epinephrine injection, probe coagulation, band ligation and hemoclips. Mechanical modalities with banding and hemoclips are safest and most effective with lower re-bleeding rate. It was interesting to note that our case had two simultaneous sources of bleeding in the form of GOV type 1 and a DL which were promptly treated. We highlight the importance of thorough endoscopic evaluation when investigating GIBs in ALDs since uncommon causes such as DL can lead to devastating outcome if not being promptly diagnosed and treated.

REFERENCES

1. Baxter M, Aly EH. Dieulafoy's lesion: current trends in diagnosis and management. *Ann R Coll Surg Engl* 2010
2. Lee YT, Walmsley RS, Leong RW, Sung JJ. Dieulafoy's lesions. *Gastrointest Endosc* 2003