Colonic Dieulafoy lesions: An Elusive Source of Gastrointestinal Bleeding

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INTRODUCTION

- Dieulafoy lesions (DL) are abnormally dilated submucosal vessels, protruding out of minute erosions in the gastrointestinal (GI) mucosa[1].
- They are responsible for less than 2% of acute GI bleeding and are relatively rare to find in the colon.
- While recent advances in endoscopy allow for better detection of DL, subtle intermittently bleeding lesions may easily be overlooked.
- Thus, DL can be challenging to diagnose, and their true incidence remains unknown. In this series, we present three cases of GI bleeding due to colonic DL.

CASE DESCRIPTION

Case 1:
- A 42-year-old woman with renal disease on hemodialysis presented with one month of generalized weakness, melena and a three-point hemoglobin drop from baseline.
- During esophagogastroduodenoscopy she developed acute onset hematochezia and hemorrhagic shock.
- A small focus of active extravasation at the hepatic flexure was identified on CT angiography but subsequent angiography was negative for active extravasation.
- On colonoscopy, an actively bleeding DL in the hepatic flexure was identified. Two hemostatic clips (HC) were successfully placed with no further bleeding.

Case 2:
- A 66-year-old man with congestive heart failure, admitted with cardiogenic shock developed intermittent episodes of hematochezia requiring pRBC.
- On colonoscopy, he was found to have an actively bleeding DL in the cecum.
- Despite four HC and hemostatic spray, he continued to have bleeding and ultimately underwent successful embolization, guided by clip location.

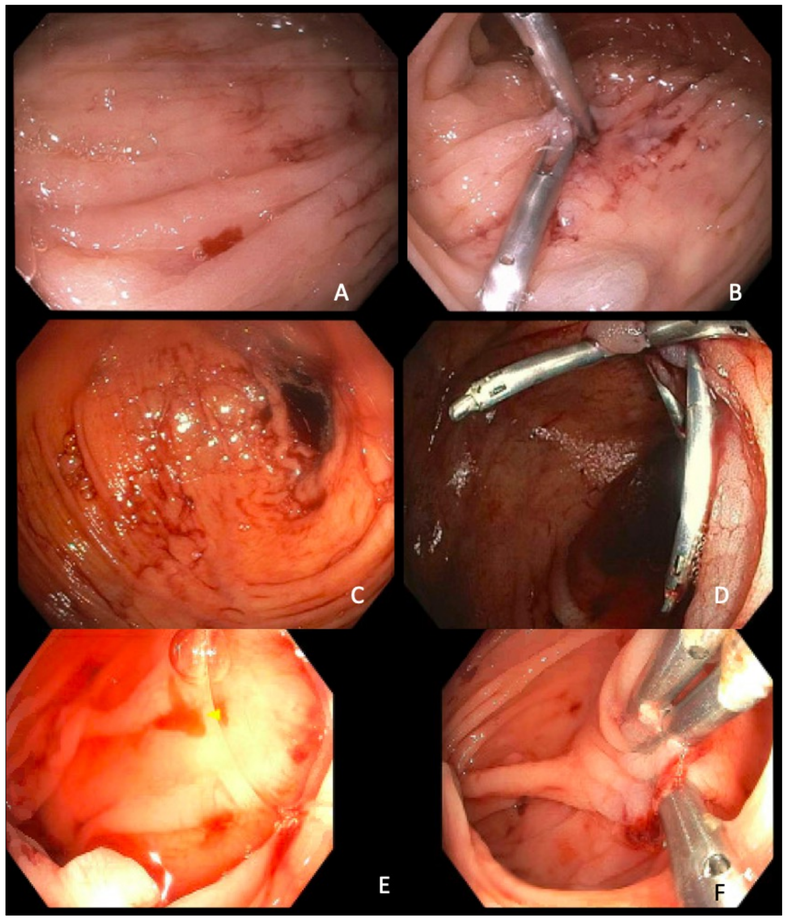

Figure 1. Case 1. Colonic DL in the hepatic flexure pre-(A) and post-clipping (B). Case 2. Case 2: Colonic DL in the caecum pre- (C)and post-clipping (D).Case 3 Colonic DL in the hepatic flexure pre-(E)and post-clipping (F).

Case 3:
- A 90-year-old man with coronary artery disease presented with two weeks of melena and four-point hemoglobin drop from baseline.
- He was transfused three units of pRBC and on colonoscopy an actively bleeding DL was found at the hepatic flexure.
- Three HC were placed with cessation of bleeding.

DISCUSSION

- Colonic DL, although rare, can cause life-threatening GI hemorrhage. Patients may be asymptomatic or present with melena, hematochezia, or bright red blood per rectum.
- At present, endoscopy is the preferred diagnostic modality for DL followed by angiography[2].
- The endoscopic management of colonic DL primarily involves epinephrine injection with clipping, and / or laser coagulation to achieve hemostasis[2].
- Interventional radiology or surgical intervention may be required in severe or refractory cases.
- It is imperative to maintain a high index of suspicion for colonic DL to arrive at an accurate diagnosis and initiate prompt treatment.

REFERENCES

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