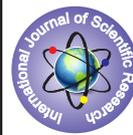


Dieulafoy's lesion of Terminal Ileum : a case report



Gastroenterology

KEYWORDS:

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ABSTRACT

BACKGROUND: Dieulafoy's lesion is an uncommon but important cause of recurrent upper gastrointestinal bleeding. Extragastric location of Dieulafoy's lesion is very rare. We report a case of Dieulafoy's lesion of the

Terminal ileum

Discussion and Result : The appropriate evaluation of small bowel bleeding, an aggressive multidisciplinary approach, such as radiologic intervention, enteroscopy, clips application and surgery, should be performed. Our case was successfully controlled with endoscopic treatment by clips application

CONCLUSIONS : The Dieulafoy's lesion of the terminal ileum is extremely rare and can be associated with massive, life-threatening hemorrhage. With advances in endoscopic techniques, enteroscopy could play a major role in the diagnosis and treatment of ileal Dieulafoy lesion bleeding.

BACKGROUND:

Dieulafoy's lesion also called *persistent caliber artery*, is a large-caliber arteriole that runs immediately beneath the gastrointestinal mucosa and bleeds through a pinpoint mucosal erosion. (1)

Originally described by Gallard in 1884 as 'miliary aneurysms of the stomach. It was more accurately distinguished by the French surgeon Georges Dieulafoy in 1898 following his study of fatal gastric haemorrhage in three asymptomatic young men.(4-5-6)

The incidence of Dieulafoy lesion varies from 0.5% to 6 %, depending upon selection criteria of total GI bleeding and accounts for between 1% and 2% of cases of major GI bleeding.

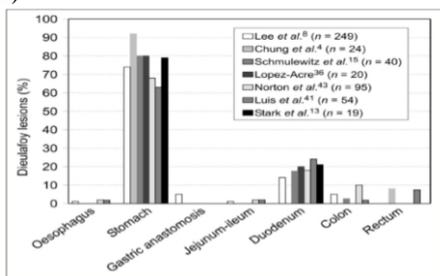
Dieulafoy's lesion is seen most commonly on the lesser curvature of the proximal stomach, with 80% to 95% being located within 6 cm of gastro-oesophageal junction causes impressive arterial hemorrhage, and may be difficult to diagnose; it is often recognized only after repeated endoscopy for recurrent bleeding. (2)

a 47-year old man with history of recurrent lower gastrointestinal bleeding . came to the emergency department because of intermittent bleeding per rectum for three days . his medical history was significant for degenerative joint disease and past history of lower GI bleeding eight months back which continued for two days and resolved spontaneously . He was taking nonsteroidal anti-inflammatory drugs for his joint pain . he had no history of surgery , allergy or recent travel . his family history was similarly unremarkable.

initially upper GI endoscopy done which showed active bleeding but site can't be located . the patient underwent colonoscopy which was un successful to detect the source of active bleeding.



Figure (1)



CT angiogram of the abdomen showed small segment of wall thickening within the terminal ileum along with suggestion of intraluminal blood clot within the distal ileum .

GI bleed RBC Labelling scan done but still site of bleeding obscure .

Capsule endoscopy done and showed normal mucosa till about five hours into study where blood was seen but no definite mucosal lesions .



Figure (2)

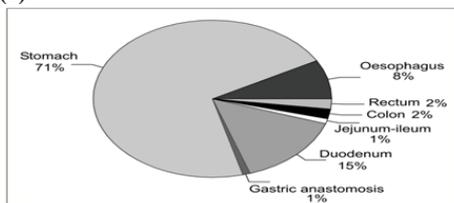


figure (1)&(2) from (4)

Dieulafoy's lesion is an uncommon but important cause of recurrent upper gastrointestinal bleeding. Extragastric location of Dieulafoy's lesion is very rare.

We report a case of Dieulafoy's lesion of the Terminal ileum

Repeated Colonoscopy showed the whole colon and terminal ileum was bloody stained up to 20-30 cm in the terminal ileum where there was a superficial , aberrant , pulsating actively oozing vessel was noted with no underlying ulceration compatible with Dieulafoy's lesion, two clips were applied after which hemostasis was secured .



Case presentation:

Discussion

The incidence of acute GI bleeding ranges from 50-150 per 100,000 of the population each year. it is caused by peptic ulcers and esophageal or gastroduodenal erosions in almost 80% of patients. (3)

Obscure GI bleeding is reported to account for up to 5% of all GI hemorrhage (4) Dieulafoys lesion is a rare but important cause of obscure GI bleeding and can lead to life threatening condition.

We reported a case of a patient who presented with recurrent massive GI bleeding from Dieulafoys's lesion of the terminal ileum And we found that small bowel bleeding continues to be difficult to visualize directly on routine endoscopy.

Therefore, diagnosis of bleeding in the small bowel is often delayed.

To localize a source of small bowel bleeding, multidisciplinary approaches such as abdominal CT, angiography, radionuclide scan, and capsule endoscopy is needed.

With the development of endoscopy, push enteroscopy is performed to diagnose and treat a bleeding source.

Push enteroscopy has two types, SBE and double-balloon enteroscopy (DBE), and two approaches, antegrade (per oral) and retrograde (per anal).

Several cases of Dieulafoys lesion bleeding have been reported most of them were treated surgically and diagnosed with histology.

However, endoscopic treatment will replace surgery in a significant portion of small bowel Dieulafoys lesion cases.

Since the widespread availability of endoscopic or angiographic treatment, surgery will play a minor role and often be left as the last therapeutic option for rebleeding lesions or after failed nonsurgical treatment.

Our case was successfully controlled with endoscopic treatment by clips application.

Conclusions

1. The Dieulafoys's lesion of the terminal ileum is extremely rare and can be associated with massive, life-threatening hemorrhage.

2. Endoscopic diagnosis of extragastric Dieulafoys's lesion can be difficult because of the small size and obscure location of the lesion.

3. This case demonstrates the importance of Increased awareness and careful and early endoscopic evaluation following the bleeding episode are the key to accurate diagnosis.

4. The application of clips is one of the important endoscopic modalities for control of bleeding.

5. The appropriate evaluation of small bowel bleeding, an aggressive multidisciplinary approach, such as radiologic intervention, enteroscopy, clips application and surgery, should be performed.

6. With advances in endoscopic techniques, enteroscopy could play a major role in the diagnosis and treatment of ileal Dieulafoys lesion bleeding.

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