

CLINICAL IMAGE

Duodenal Dieulafoy's lesion

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Received: 3/12/2021. Accepted: 6/14/2021. Published: 6/30/2021.

Am j Hosp Med 2021 Jun;5(2):2021. DOI: DOI: <https://doi.org/10.24150/ajhm/2021.008>

Keywords: Acute upper gastrointestinal bleeding (UGIB), Clipping, Dieulafoy's lesion (DL), Duodenal, Endoscopy.



Figure 1: Upper endoscopy demonstrating protruding vessel in the duodenal sweep with normal surrounding mucosa – Dieulafoy's lesion.

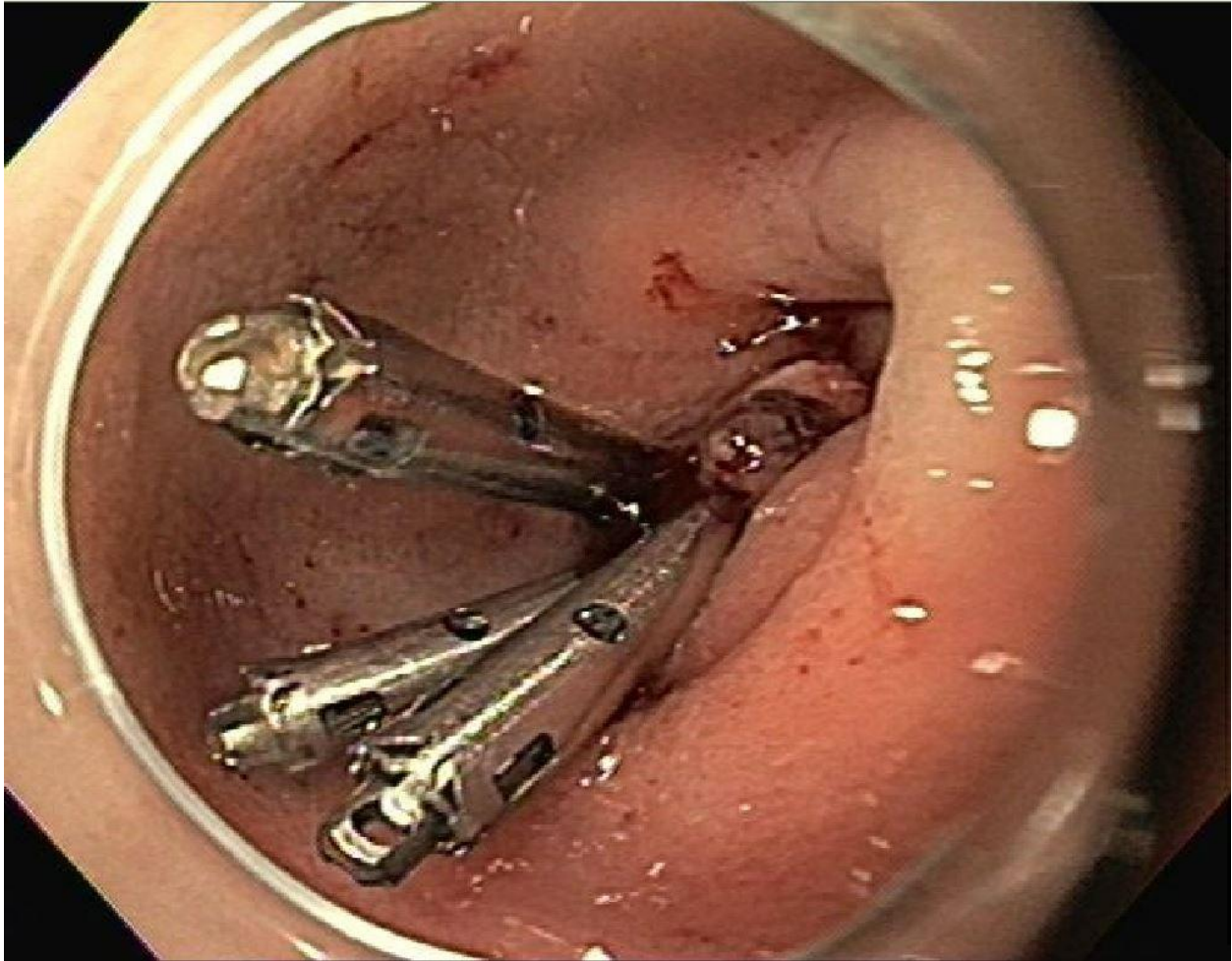


Figure 2: Several hemoclips were deployed to the base of the bleeding vessel resulting complete hemostasis.

CASE:

A 92-year-old female presented to hospital with one week history of black tarry stools that was associated with generalized weakness and fatigue. She denied dizziness, hematemesis, hematochezia, or abdominal pain. She had medical history of myelodysplastic syndrome, gastroesophageal reflux disease, and hypertension. On admission, she was hemodynamically stable, her physical exam was unremarkable. Initial Hgb was noted to be 5.7 g/dL with baseline Hgb of 9.0 g/dL. Her chemistry was notable for elevated BUN of 40 mg/dL and creatinine of 1.0 mg/dL. Her INR and platelet

counts were normal. She was given intravenous proton pump inhibitor and two units of packed red blood cells. Following initial medical treatment, an urgent upper endoscopy was performed, which demonstrated an actively spurting visible vessel in duodenal sweep with normal surrounding mucosa consistent with Dieulafoy's lesion (DL) (Figure 1). A complete hemostasis was achieved with dual therapy of sub-mucosal epinephrine injection, followed by deployment of seven hemoclips (Figure 2). Post-procedure Hgb remained stable at 8.5 g/dL and subsequently, she was discharged home after 3-days of hospital stay.

DISCUSSION:

Acute upper gastrointestinal bleeding (UGIB) is one of the most common reasons of inpatient gastroenterology consultations (1). Acute UGIB is classified into non-variceal and variceal bleeding. The most common cause of acute non-variceal UGIB is peptic ulcers (30–67%), followed by esophagitis (4-12%). Other causes include Mallory–Weiss syndrome, upper GI malignancies, gastric and duodenal erosions, and vascular lesions (angioectasia and DL) (2).

DL is relatively rare and represents 1.5% of UGIB (3). It is constituted of an aberrant large and submucosal vessel that erodes through the epithelium. It is most commonly located in the lesser curvature of

the stomach within 6 cm of the gastro-esophageal junction (4). Duodenum is a rare location of DL (5). Diagnosis of the DL might be challenging due to the intermittent pattern of bleeding. Endoscopy is the mainstay diagnostic and therapeutic modality. Endoscopic diagnostic criteria of DL including arterial spurting from a (<3 mm) mucosal defect encircled with normal mucosa, a projecting vessel within normal surrounding mucosa and/or fresh clots with a small point of attachment to the mucosal defect or normal mucosa (4). Endoscopic treatment is the main stay of the bleeding control and commonly hemostasis is reached with combination therapies including local injection of epinephrine, coagulation (thermal), or mechanical therapy (banding or clipping) (1, 4).

Notes

Potential conflicts of interest: The author reports no conflicts of interest in this work.

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