

Dieulafoy Lesion In The Rectum: A Case Report

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ABSTRACT

Approximately 20% of gastrointestinal tract bleedings originate from the lower Gastrointestinal Tract (GIT). Although many of these bleedings are spontaneously stop, they cause mortality and morbidity especially in the elderly patient population. The most common causes of lower GIS bleeding are diverticulosis coli and angiodysplasia. Less common causes are ischemic colitis, colon tumors, hemorrhoids and solitary rectal ulcer. Dieulafoy lesion is a large superficial artery underlying a mucosal defect which usually occurs in the proximal stomach. It can cause serious life-threatening GI bleeding and rarely seen in lower GIT. Here we report a 80-years-old male patient who admitted to the emergency department because of bloody stool and diagnosed rectal Dieulafoy lesion treated by endoscopically.

KEYWORDS

Dieulafoy lesion, Rectum, Gastrointestinal Bleeding

CASE REPORT

An 80-year-old man patient known case of diabetes mellitus, hypertension and atrial fibrillation was admitted to the emergency department with the complaint of new onset red color defecation. The patient was taking rivaroxaban 20 mg daily for atrial fibrillation. His blood pressure was 140/90 mmHg and pulse was 72 beats per minute. Hematochezia was determined in the rectal examination of the patient. Washing away from the nasogastric tube showed that the content was pure bile fluid. Hemoglobin level of the patient was 13.9 g/dL. His platelet count and coagulation parameters were in normal range. In the emergency department, the patient's hemoglobin value fell to 11.7 g/dL and blood pressure dropped. Computed Tomography Angiography (CTA) was performed to determine the location of bleeding. Contrast extravasation from rectal wall was identified (Figure 1). The patient underwent urgent colonoscopy without full bowel preparation. Dieulafoy lesion with protruding and oozing vessel was detected 3 cm away from the anal verge (Figures 2 & 3). The mucosa around the lesion was in normal appearance. After the injection of dilute adrenaline (1:10000) to the edges of the lesion, three hemoclips were applied on the oozing vessel (Figure 4). The bleeding stopped after the successful endoscopic treatment and did not recur during the follow-up period.

DISCUSSION

The term of lower GIT bleeding was used to for hemorrhage from under the Trietz ligament but with developing imaging and endoscopic examinations now used for mostly bleeding from the colon and rectum. Small bowel bleeding is considered as a separate entity [4]. Patients usually present with hematochezia. Sometimes they also present with melena in right colon or cecum bleeding. Colonoscopy is the first procedure to be used for both diagnostic and therapeutic purposes. If the patient has persistent bleeding with hemodynamic instability that cannot tolerate bowel preparation, radiographic interventions like angiography can be considered after upper GI bleeding excluded [5,6].

Dieulafoy lesion causes bleeding after submucosal artery opening from the small mucosal defect to the lumen. Lesions account for 1-2%

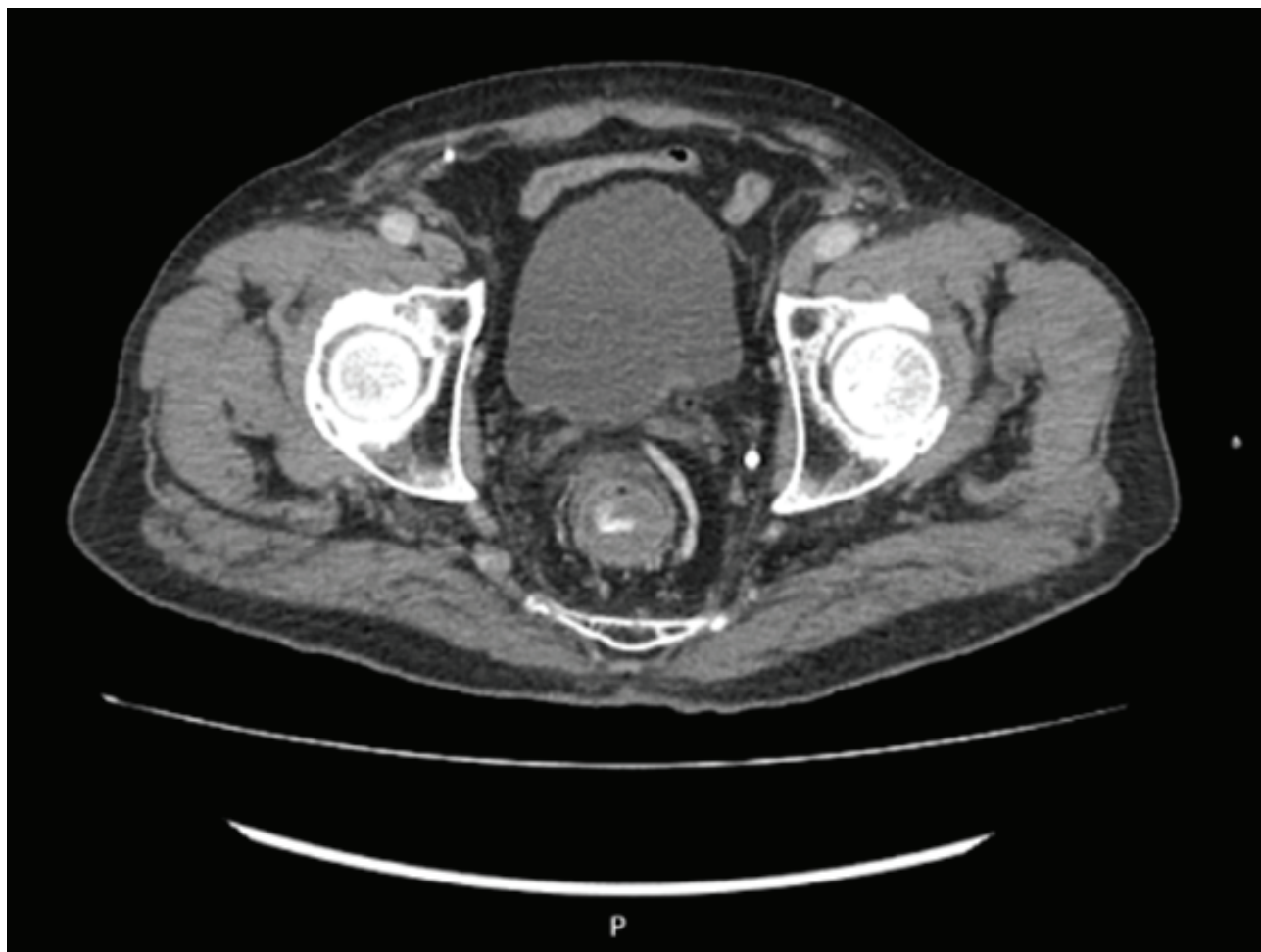
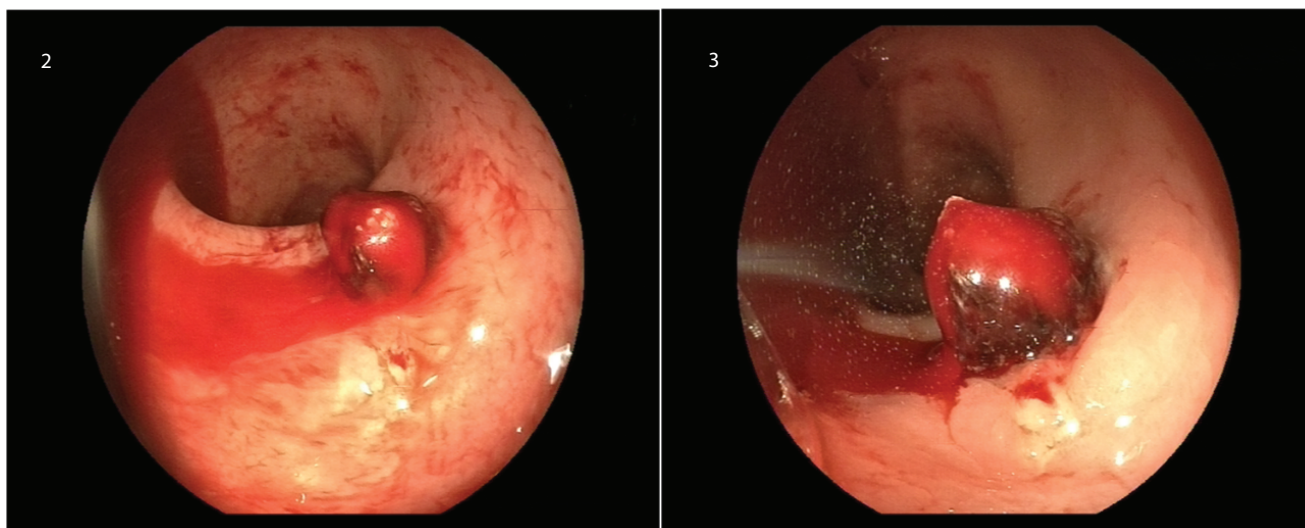


Figure 1: CTA image shows contrast extravasation form rectal wall



Figures 2 & 3: Dieulafoy lesion with protruding vessel in the rectum

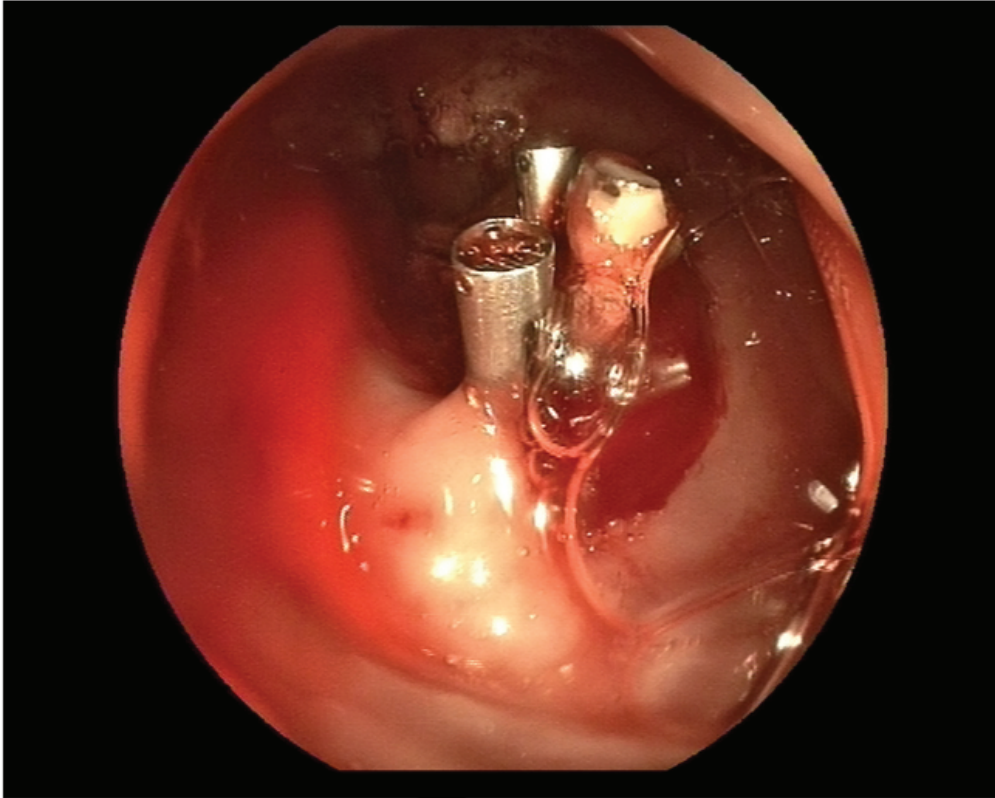


Figure 4: After endoscopic treatment with adrenaline and hemoclips

of the all causes of GI bleeding and more seen in male patients. There are cases reported in the small intestine, colon, rectum and anorectal junction. As we found in our patient, lesions in the rectum are reported rarely.

Diagnosis is made by endoscopy following these criteria:

1. Bleeding from small (< 3 mm) mucosal defects surrounded by normal mucosa;
2. The presence of protruding vessels;
3. Fresh clots attached to a small mucosal defect or to normal mucosa [7].

Due to intermittent massive bleedings, endoscopic hemostasis is warranted. Endoscopic treatment is successful in over 90% of patients [8]. Injection sclerotherapy, adrenaline injections, band ligation, hemoclips, contact thermal coagulation, argon plasma coagulation can be used to stop bleeding or rebleeding [9]. Mechanical treatment models such as band or hemoclips appear to be more effective [10]. We preferred to treat the lesion with hemoclips after improving the image area with adrenaline injection. If endoscopic treatment fails, angiographic therapies or surgery should be considered. In patients with massive lower GI bleeding or occult bleeding, Dieulafoy should be considered in the differential diagnosis and should receive endoscopic treatment due to high success rates.

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CONFLICTS OF INTEREST

The authors have no financial conflicts of interest.

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