Turk J Gastroenterol 2005; 16 (3): 178-179

LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
Upper gastrointestinal bleeding caused by simultaneous dieulafoy's lesion and pre-pyloric peptic ulceration

Dieulafoy's lezyon ile pre-pylorik ülserin eşzamanlı sebep olduğu üst GİS kanama

Ahmet GÜRER[1], Mehmet ÖZDOĞAN[1], Nuraydın ÖZLEM[1], Vedat ÖZTÜRK[1], İsmail GÖMCELİ[1], Eyüp SELVİ[2], Raci AYDIN[1]

Departments of [1]General Surgery and [2]Department of Gastroenterology, Atatürk Eğitim ve Araştırma Hospital, Ankara

To the Editor

We present herein a case of massive upper gastrointestinal (GI) bleeding due to simultaneous Dieulafoy's lesion and pre-pyloric peptic ulcer. To our knowledge, there has been no previous report of the simultaneous occurrence of these two different causes of upper GI bleeding in the English literature.

An 84-year-old male patient admitted to our emergency room with upper GI bleeding. He had massive hematemesis on admission. He had no history of alcohol or non-steroidal anti-inflammatory drug consumption or abdominal trauma. After initial fluid resuscitation, the patient underwent upper GI endoscopic examination. Endoscopy showed active arterial bleeding through a pre-pyloric peptic ulcer (1 cm in size) (Figure 1a). Bleeding was stopped by heater probe coagulation. Parenteral proton pump inhibitor infusion was commenced. Recurrent bleeding through nasogastric suction occurred 48 hours later. The second attempt at endoscopic examination revealed an actively bleeding Dieulafoy's lesion located in the posterior wall of the gastric fundus (Figure 1b). A combination of sclerotherapy (2% aetoxysclerol) and heater probe coagulation was applied to the lesion. The post-endoscopic course was normal and the patient was discharged on the sixth day after admission.

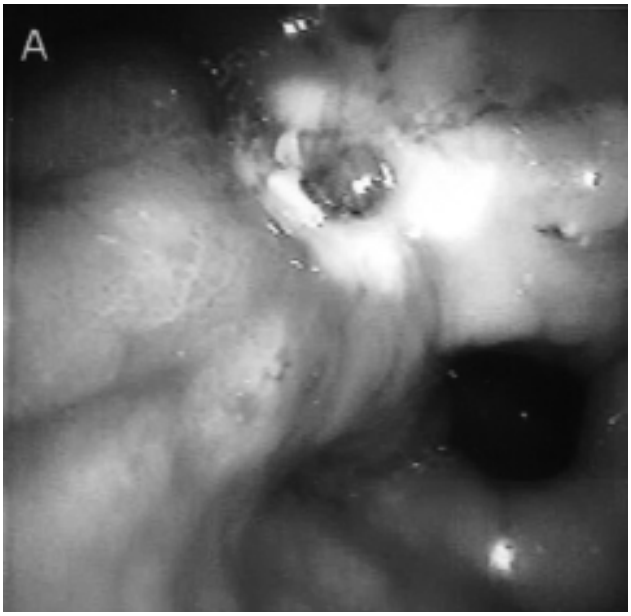

Figure 1: a) Endoscopic image of bleeding pre-pyloric peptic ulcer (1 cm)

Dieulafoy's lesion is usually located in the proximal stomach, generally along the lesser curvature. It has, however, been found increasingly throughout the GI tract (1, 2). The most widely accepted explanation for the location of this lesion is based on the gastric blood supply. Typically, an abnormally large submucosal arterial vessel protrudes through a solitary, minute mucosal defect and ruptures spontaneously (3, 4).

Address for correspondence: Ahmet GÜRER
Başkent Sitesi A1 Blok No: 5 Çankaya 06550, Ankara, Turkey
Phone: +90 312 440 24 80
E-mail: ahmetgurer@hotmail.com

Manuscript received: 24.01.2005 **Accepted:** 08.02.2005

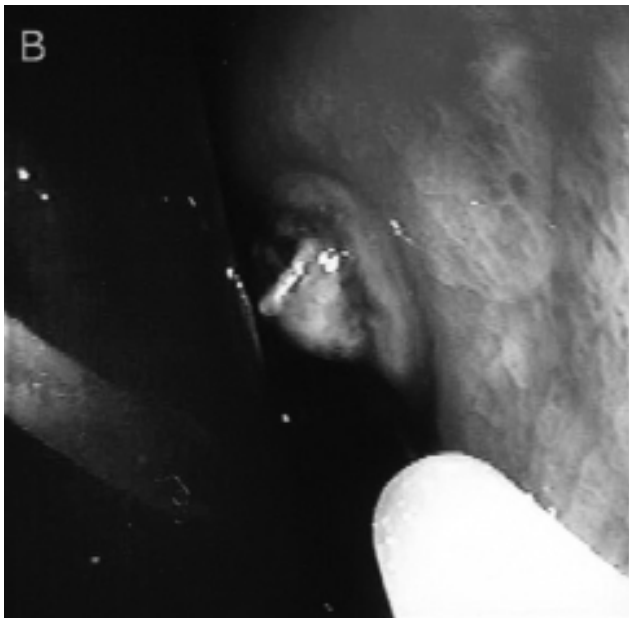

Figure 1: b) The image of the bleeding Dieulafoy's lesion on second endoscopic examination

Endoscopic methods have recently become the standard as both diagnostic and therapeutic approaches and have decreased mortality (5). In large series, endoscopic hemostasis has been successful in 85 to 96% of patients (6, 7). Angiographic therapy is the alternative modality, but its role remains limited for gastric Dieulafoy's lesion; the surgical intervention is reserved for failure of endoscopic and angiographic therapies.

As mentioned previously, there is no consistent association with peptic ulcer disease. In our patient with simultaneous Dieulafoy's lesion and pre-pyloric peptic ulceration, the association might be incidental. Because of missed bleeding from the gastric Dieulafoy's lesion, the patient re-bled and second endoscopy was required. Less frequent causes of upper GI bleeding, such as Dieulafoy's lesion and its possible association with peptic ulceration, must be in the endoscopist's armamentarium in the evaluation of the patient with upper GI bleeding.

REFERENCES

1. Arora A, Mehrotra R, Patnaik PK, et al. Dieulafoy's lesion: a rare cause of massive upper gastrointestinal haemorrhage. Trop Gastroenterol 1991; 12: 25-30.
2. McClave SA, Goldschmid S, Cunningham JT. Dieulafoy's cirsoid aneurysm of the duodenum. Dig Dis Sci 1988; 33: 801-5.
3. Broberg A, Ihre T, Pyk E, et al. Exulceratio simplex as a conceivable cause of massive gastric hemorrhage. Surg Gynecol Obstet 1982; 154: 186-8.
4. Strong RW. Dieulafoy's disease: a distinct clinical entity. Aust NZ J Surg 1984; 54: 33-6.
5. Chaer RA, Helton WS. Dieulafoy's disease. J Am Coll Surg 2003; 196: 290-6.
6. Reilly HF, Al-Kawas FH. Dieulafoy's lesion. Diagnosis and management. Dig Dis Sci 1991; 36: 1702-7.
7. Norton ID, Peterson BT, Sorbi D, et al. Management and long-term prognosis of Dieulafoy lesion. Gastrointest Endosc 1999; 50: 762-7.