

P2259 - Rare Obscure Cause of Upper Gastrointestinal Bleeding: Bleeding Duodenal Lymphangiectasia

 Tuesday, October 29  10:30 AM - 4:00 PM

 Location: Exhibit Halls 3 and 4 (Street Level)

Presenting Author(s)



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Introduction: While ulcerative and erosive mucosal changes are more commonly the culprit lesion of upper gastrointestinal bleeding, bleeding can also occur from traumatic, malignant or vascular lesions. An unusual and infrequent vascular cause of bleeding is from a focal intestinal lymphangiectasia (IL). We describe a patient who presented with bleeding from a duodenal IL.

Case Description/Methods: A 94-year-old female was sent by her nursing home for witnessed melena and new onset normocytic anemia with a hemoglobin of 7 g/dl. She was unable to provide a reliable history due to her advanced dementia. Her medical history was unknown. She was hypotensive on presentation which she responded to fluid resuscitation and one unit of blood transfusion. Her physical examination revealed conjunctival pallor, benign abdominal exam and melanotic stool on rectal exam. EGD was performed. The esophagus and stomach was normal. In the second portion of the duodenum, there was a five millimeter white plaque-like lesion, consistent with IL, and with a central red erythematous spot, appearing eroded [Figures 1-2]. In the view of bleeding and absence of other potential sources of bleeding, three hemostatic clips were placed to the lesion for hemostasis and prevent further bleeding [Figure 3]. Patient was followed clinically over the next several days and her bowel movements became brown in color. She required no further blood transfusions and hemoglobin levels stabilized. She was discharged with a hemoglobin of 8.7 and determined to have had bleeding from a duodenal IL.

Discussion: IL is characterized by dilated lymphatic vessels, which can be focal or diffuse. Generally asymptomatic, IL can be associated with malabsorption. Acute gastrointestinal bleeding is rare. An obstructed normal efferent lymphatic flow could subsequently open a latent lymphatic-venous/arterial connection, which could potentially explain its association with bleeding. Unless actively bleeding or with recent stigmata of bleed, definite diagnosis of bleeding from a focal IL is difficult. Endoscopic treatment is amendable to the same therapeutic interventions available of any

bleeding gastrointestinal lesions, which includes injection of epinephrine, thermal therapy and/or placement of hemostatic clips. In conclusion, focal type of IL may rarely present with acute obscure gastrointestinal bleeding. Physicians should remain cognizant of this infrequently-described-in-literature etiology and should include it in their differential diagnosis.



Figure 1: An eroded duodenal lymphangiectasia with central red erythematous spot.



Figure 2: An eroded duodenal lymphangiectasia with central red erythematous spot.



Figure 3: Placement of three hemoclips to an eroded duodenal lymphangiectasia.

Disclosures:

Sufian Sorathia indicated no relevant financial relationships.

Rulz Cantave indicated no relevant financial relationships.

Vivek Choksi indicated no relevant financial relationships.

Kairavee Dave indicated no relevant financial relationships.

Steven Kaplan indicated no relevant financial relationships.

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