MASSIVE HAEMATEMESIS DUE TO DIEULAFOY'S LESION

(A Case Report)

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Introduction

A definite cause for upper gastrointestinal haemorrhage cannot be made out in approximately 4-9 per cent of cases [1]. Dieulafoy's lesion is an uncommon and often overlooked cause of massive recurrent upper gastrointestinal haemorrhage. The lesion derives its name following the classical description by Dieulafoy in 1898. Often, repeated endoscopic examinations are needed prior to reaching this diagnosis. Surgery is considered as the best form of treatment and a wide local excision is recommended [2]. We report our experience with successful surgical management of such a lesion.

Case Report

A 32-year-old serving soldier presented to a peripheral hospital with history of massive haematemesis amounting to approximately 600 ml following an alcoholic binge. He gave no history of peptic ulcer disease or haematemesis in the past. He was managed by ice cold gastric lavage, injection ranitidine and blood transfusion. Bleeding stopped spontaneously with therapy. The patient was transferred to Command Hospital (Eastern Command). Barium meal examination and upper gastrointestinal endoscopy done showed no evidence of esophageal varices, gastric or duodenal pathology. During the period of admission, 3 weeks following the first episode of haematemesis, the patient had another bleed. Emergency endoscopy could not localise the lesion.

He was stabilized and taken up for an emergency laparotomy. At surgery no obvious gastrointestinal pathology was seen from the external surface. A longitudinal gastrotomy was done and blood clots were evacuated. A 0.25 cm area of superficial mucosal ulceration with a spurting blood vessel was noted 4 cm from the gastroesophageal junction towards the fundus of the stomach. A diagnosis of Dieulafoy's lesion was made and a wedge resection of the area was performed. The patient made an uneventful post-operative recovery and has remained symptom free one year following surgery. Histopathology was consistent with Dieulafoy's lesion.

Discussion

Dieulafoy's lesion is an uncommon cause of mas-

sive, recurrent upper gastrointestinal bleeding. The exact incidence of the lesion is not known, possibly due to its rarity and propensity to be overlooked easily [2]. In a study of over 900 cases of upper GI bleed Arora et al reported an incidence of 0.67 per cent [3]. It is commonly seen after the age of fifty and is about twice as common in men than women [1]. History suggestive of peptic ulcer disease or alcohol abuse is usually absent. The lesion is characteristically seen 6 cm from the gastroesophageal junction in over 80 per cent of the cases. It is known to occur in other areas of the stomach, jejunum, colon, esophagus and bronchus.

The bleeding vessel in Dieulafoy's lesion is an unusually large submucosal vessel with a constant calibre of 1-3 mm traversing a varying length in the submucosa. No degenerative or inflammatory changes are seen in the submucosa of the stomach or the vessel wall, thus refuting the theory of atherosclerosis or gastric ulcer as an etiology of the bleed [2]. This calibre-persistent arteriole takes an abnormal origin from the arterial chain outside the gastric wall instead of the arborizing submucosal network of blood vessels [4].

Surgery is the preferred modality of therapy as it allows removal of the entire segment of stomach having the vascular abnormality [2]. Various non-surgical modalities of therapy have been used in the recent years, including sclerosant injection, cauterization, selective embolization and band ligation. The endoscopic therapy selectively addresses the bleeding site and thus leaves behind the abnormal blood vessel which is known to traverse a variable distance in the submucosa, leaving the patient prone to develop further episodes of haematemesis. Therapeutic endoscopic manipulation high up in the stomach near the cardia is difficult and needs expertise of a very high order [2,5]. Early surgical intervention allows a defini-

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tive diagnosis and treatment and thus a decline in mortality.

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