Dieulafoy's lesion of the rectum

The patient is a 59-year-old woman with Goodpasture's disease on immunosuppressants presenting with hemodynamically significant gastrointestinal bleeding (GIB) requiring blood product transfusion and intensive care unit admission. Initial colonoscopy was notable only for a few non-bleeding, superficial rectal ulcers and a large fecolith. One week thereafter, the patient developed haemorrhagic shock from another GIB, haemoglobin of 5.2 g/L and substantial bright red blood per rectum necessitating emergent blood product resuscitation.

Mesenteric arteriography revealed active extravasation in the rectum (figure 1). Angiographic embolisation with gelform was successful, but she still required additional treatment due to collaterals. Follow-up colonoscopy revealed a single pulsatile visible artery protruding from the 9 O'clock position within the rectal mucosa, 3 cm from the rectum. It was consistent with a Dieulafoy's lesion (DL) (figure 2) and was definitively treated with a single epinephrine injection and application of two mechanical clips.

DL is a dilated aberrant submucosal arterial vessel of unknown aetiology, typically located in the proximal stomach and duodenum. They are rarely found in other parts of GI tract such as the rectum in this case. DL may lead to massive GI bleeding. According to Baxter and Aly, DL is theorised to occur due to localised mucosal ischaemic damage and acquired vascular ectasia, which erodes through atrophic mucosa.¹ The patient most likely had a predisposition secondary to her prednisone use.

Ki Suk Eum,¹ Kyler Kozacek,¹ Caleb Hudspath,¹ Jessica Bunin,² Franklin Goldwire³

¹Department of Medicine, Tripler Army Medical Center, Honolulu, Hawaii, USA

²Department of Medicine, Walter Reed Army Medical Center, Bethesda, Maryland, USA

Figure 1 Mesenteric arteriography with contrast extravasation.

Figure 2 Endoscopic visualisation of a rectal Dieulafoy's lesion.

³Department of Gastroenterology, Tripler Army Medical Center, Honolulu, Hawaii, USA

Correspondence to Dr Ki Suk Eum, Department of Medicine, Tripler Army Medical Center, Honolulu, HI 96859, USA; petereum86@gmail.com

Collaborators K Bogenberger, S Nguyen.

Contributors KSE, KK, CH, JB and FG made substantial contributions to conception and design and have been involved in drafting the manuscript or revision. All authors agree to be accountable for all aspect of the work. FG approved the final version to be published.

Funding This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

OPEN ACCESS

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

© Author(s) (or their employer(s)) 2019. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

To cite Eum KS, Kozacek K, Hudspath C, *et al.* *Postgrad Med J* 2019;**95**:568.

Received 20 April 2019

Revised 13 June 2019

Accepted 28 June 2019

Published Online First 12 July 2019

Postgrad Med J 2019;**95**:568.

doi:10.1136/postgradmedj-2019-136503

REFERENCE

- 1 Baxter M, Aly EH. Dieulafoy's lesion: current trends in diagnosis and management. *Ann R Coll Surg Engl* 2010;**92**:548–54.