The Turkish Journal of ***Academic Gastroenterology*** • *2024; 23(2): 76-77*
Manuscript Received: *15.09.2023* • ***Accepted:*** *18.09.2023*

LETTER TO THE EDITOR

A rare cause of lower gastrointestinal bleeding: Rectal dieulafoy's lesion

Alt gastrointestinal kanamanın nadir bir nedeni: Rektal dieulafoy lezyonu

Bünyamin SARITAŞ, Duran Deha ÇETİN, Mustafa HARI, Şehmus ÖLMEZ

Department of Gastroenterology, Health Sciences University Adana City Training and Research Hospital, Adana, Turkey

To the editor;

A Dieulafoy's lesion (DL) is defined as a dilated submucosal vessel that erodes the overlying epithelium without evidence of a primary ulcer or erosion (1). This lesion is usually seen in upper gastrointestinal system (GIS) and mostly in the stomach. DL in rectum is rare (1,2). It may cause life threatening bleeding (1). Nowadays, its' incidence is higher than before due to more use of endoscopy and with the development of endoscopic therapy modalities it's mortality and surgical interventions are lower (3). Here we report a very rare case of DL in rectum presenting with hematochezia and successfully treated with sclerotherapy and endoclips.

Eigthy years-old female patient admitted to emergency department of our hospital for decreased oral intake and poor general status. She had hypertension, diabetes mellitus, atrial fibrillation, and ischemic cerebrovascular disease before. She was hospitalized to intensive care unit for acute kidney failure and hypernatremia. At the third day of intensive care unit, she had rectal bleeding. On physical examination Blood pressure: 90/60 mmHg, pulse: 110 /min. Her general status was poor, she was pale. There was fresh blood on rectal examination. Laboratory data on admission was as follows: glucose: 304 mg/dL, urea: 154 mg/dL, creatinin: 2.77 mg/dL, albumin: 30 g/L, sodium: 152 mmol/L, white blood cell (WBC): 10.1 10^3/µl, hemoglobin: 9.8, international normalized ratio (INR): 1.19, other laboratory values were normal. Rectoscopy revealed spurting Dieulafoy's lesion in rectum. Her bleeding was controlled by two endoclips (Figure 1). She had one unit of erythrocyte transfusion during hospitalization. No rebleeding occurred during follow up. Her representative gave written consent regarding this article.

The etiology of DL is unknown. But patients have concomitant ischemic heart disease, hypertension, diabetes and chronic renal failure. Our patient had ischemic heart disease, hypertension, diabetes (2,4).

Early diagnosis and proper endoscopic treatment are very important in patients with Dieulafoy's lesion. Bleedings originated from DL increases hospital bills. Increased costs are related to increase in diagnosis of DL, lower visibility than other bleeding lesions on admission and more rebleeding rates (3), thus leading to more complication and more duration of hospital stay (3).

Correspondence: Bünyamin Sarıtaş • Health Sciences University, Adana City Training and Research Hospital, Department of Gastroenterology, Adana, Turkey • Phone: +90 322 455 90 00 Fax: +90 322 344 03 05 • E-mail: bunyamine@hotmail.com • *Sarıtaş B, Çetin DD, Harı M, et al. • A rare cause of lower gastrointestinal bleeding: Rectal dieulafoy's lesion • The Turkish Journal of Academic Gastroenterology 2024;23:76-77.* ***Doi: 10.17941/agd.1509362***

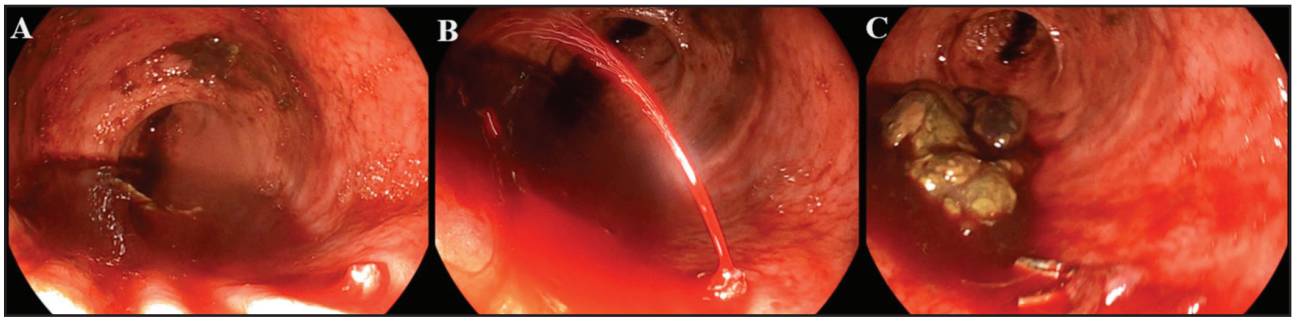

Figure 1 Dieulafoy's lesion oozing **(A),** spurting **(B)** and after hemoclip application **(C).**

Different endoscopic treatment modalities exist, endoscopic band ligation (EBL), and endoscopic hemoclip (EHC) are the most used treatment modalities (1,3,5). These modalities cause minimal tissue injury. There is no significant difference between EBL or EHC by means of primary hemostasis or prevention of rebleeding (6). EHC is the most used modality in the treatment of rectal DL (5). Endoclip is frequently used treatment method because of its ease of use, low cost, safety and effectivity and availability in many endoscopy units (7). In our case we diagnosed DL in first endoscopic examination, and we applied two EHC. No rebleeding occurred during follow up.

Conflict of Interest: *All authors declare no conflict of interest and no financial support regarding this article.*

REFERENCES

1. Baxter M, Aly EH. Dieulafoy's lesion: current trends in diagnosis and management. Ann R Coll Surg Engl. 2010;92(7):548-54.
2. Massinha P, Cunha I, Tomé L. Dieulafoy Lesion: Predictive Factors of Early Relapse and Long-Term Follow-Up. GE Port J Gastroenterol. 2020;27(4):237-243.
3. Chakinala RC, Solanki S, Haq KF, et al. Dieulafoy's Lesion: Decade-Long Trends in Hospitalizations, Demographic Disparity, and Outcomes. Cureus. 2020;12(7):e9170.
4. Nojkov B, Cappell MS. Gastrointestinal bleeding from Dieulafoy's lesion: Clinical presentation, endoscopic findings, and endoscopic therapy. World J Gastrointest Endosc. 2015;7(4):295-307.
5. Inayat F, Hussain A, Yahya S, et al. Rectal Dieulafoy's lesion: a comprehensive review of patient characteristics, presentation patterns, diagnosis, management, and clinical outcomes. Transl Gastroenterol Hepatol. 2022;7:10.
6. Barakat M, Hamed A, Shady A, Homsi M, Eskaros S. Endoscopic band ligation versus endoscopic hemoclip placement for Dieulafoy's lesion: a meta-analysis. Eur J Gastroenterol Hepatol. 2018;30(9):995-996.
7. Kinoshita K, Matsunari O, Sonoda A, et al. A case of the lower gastrointestinal bleeding due to Dieulafoy's ulcer in the cecum. Clin J Gastroenterol. 2020;13(4):564-567.