

Rectal Dieulafoy Lesion

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A 68-year-old man presented with sudden onset of massive hematochezia. His medical history included polycystic kidney, chronic renal failure on maintenance hemodialysis, and chronic constipation. He had had renal transplantation six weeks before. His medication included methyl prednisolone but no anti-platelet agents. On examination, his temperature was 36.4°C, blood pressure was 85/60 mmHg, and heart rate was 106 beats per minute. Laboratory examination showed white blood cells of $4.2 \times 10^3/\mu\text{L}$, hemoglobin of 10.2 g/dL, platelets of $330 \times 10^3/\mu\text{L}$, blood urea nitrogen of 17 mg/dL, creatinine of 2.3 mg/dL, and albumin of 3.5 g/dL. After fluids and blood transfusion stabilized vital signs, an enhanced computed tomography (CT) scan disclosed active extravasation in the rectum (Fig. 1). Subsequent colonoscopy showed massive fresh blood and an exposed vessel in the rectum (Fig. 2A). Closer observation disclosed a protruding pulsatile vessel without surrounding ulceration, consistent with Dieulafoy lesion (Fig. 2B). Endoscopic hemoclipping was successful for immediate and sustained hemostasis (Fig. 2C).

Dieulafoy lesions are characterized by a submucosal large-caliber arteriole protruding through a small mucosal

defect, which causes acute life-threatening gastrointestinal hemorrhage.^{1,2} Most Dieulafoy lesions are detected in the proximal stomach and rectal Dieulafoy lesions are rare. According to a comprehensive review of 14 patients with Dieulafoy lesions of the colon and rectum, most of them are the older male patients and have hypertension, diabetes mellitus, or chronic renal failure as the underlying diseases



FIG. 1. An enhanced computed tomography scan disclosed active extravasation (arrow) in the rectum.

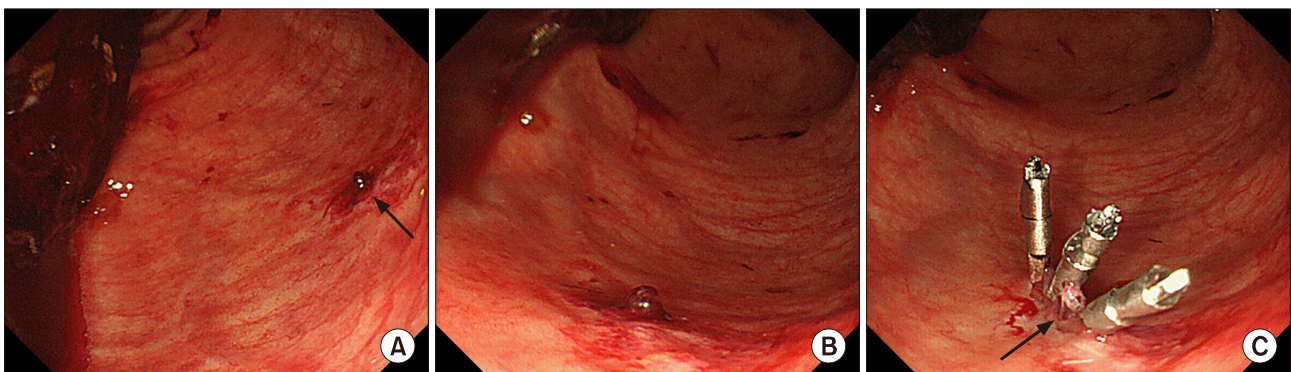


FIG. 2. (A) Colonoscopy showed massive fresh blood and an exposed vessel (arrow) in the rectum. (B) Closer observation disclosed a nipple-like pulsatile vessel without surrounding ulceration, consistent with Dieulafoy lesion. (C) Hemostatic clips were deployed to the Dieulafoy lesion (arrow), achieving successful hemostasis.

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suggesting vascular pathologies as an inciting factor.² It is sometimes difficult to detect the Dieulafoy lesions because of the minute size and intermittent nature of hemorrhage. Enhanced CT helps detect the lesions, as shown in this case. Hemostasis can be successfully achieved by endoscopic therapy. The mechanical methods, such as clipping and band ligation, are safe and effective for rectal Dieulafoy lesions with the advantages including less damage to the surrounding tissue than other modalities as the colorectal bowel wall is thin.¹⁻⁴ In conclusion, although rare, Dieulafoy lesions should be included in the differential diagnosis of acute massive hematochezia in the elderly with underlying diseases.

CONFLICT OF INTEREST STATEMENT

None declared.

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