

# Duodenal Dieulafoy's Lesion-arising Awareness of this Rare Cause of Gastrointestinal Bleed

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## **Authors' contributions**

*This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.*

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**Case Study**

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## **ABSTRACT**

**Aim:** The aim of this report is to raise awareness about the risk of bleeding associated with duodenal Dieulafoy lesions (DLs) and to emphasize the importance of utilizing imaging modalities when DLs are suspected as the cause of bleeding.

**Presentation:** This case study reports a 68-year-old male who presented with non-bloody vomiting and multiple episodes of hematochezia. An angiogram revealed active bleeding in the duodenum,

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which was subsequently identified and treated on the first attempt during endoscopy as a bleeding duodenal DL.

**Discussion:** DLs are a rare cause of gastrointestinal bleeding, characterized by dilated submucosal vessels that have a tortuous path, making them susceptible to erosion. They are most commonly found in the stomach, and are extremely rare in the duodenum, often requiring multiple endoscopic attempts to identify and treat. However, we were able to successfully treat our patient upon the first attempt with the help of angiogram prior to endoscopy. Use of multiple methods to achieve hemostasis (epinephrine injection, heat probe, and hemoclips) is effective in treating DLs.

**Conclusion:** It is important to recognize DLs as a potential cause of gastrointestinal bleeding, given their high mortality rate. The use of imaging prior to endoscopy can potentially prevent the need for multiple attempts at identifying and treating the lesion.

**Keywords:** Duodenal Dieulafoy's lesion; endoscopy; upper gastrointestinal bleed; hemocliping; heat probe; epinephrine injection.

## 1. INTRODUCTION

"Acute upper gastrointestinal (GI) bleeding is a medical emergency that can lead to unstable hemodynamic status and put patients at risk for significant morbidity and mortality if not promptly diagnosed and managed. The upper GI tract, which includes the esophagus, stomach, and duodenum, is a common source of bleeding, and rapid blood loss from these sites can cause hemodynamic instability, leading to shock and even death in some cases. Peptic ulcer disease is the most common cause of upper GI bleed, accounting for approximately 50% of all cases, while bleeding from Dieulafoy's lesions (DL) accounts for only 1-2% of acute GI bleeding"[1].

Dieulafoy's lesions (DLs), also called "calibre persistent artery," are abnormally dilated and exposed vessels in the submucosal layer of the gastrointestinal (GI) tract that protrude through a small puncture in the overlying normal mucosal tissue [2]. These lesions are most commonly located in the proximal stomach within 6cm of the gastroesophageal junction, but can rarely, about 15% of the time, be found in the duodenum [1]. "The rarity of DL can be attributed to the lack of awareness about its existence. However, this lack of awareness can lead to a previously reported mortality rate of up to 80% associated with this lesion" [3]. This paper aims to increase awareness of DL as a significant cause of gastrointestinal bleeding by presenting a case of a patient with bleeding from a duodenal lesion.

## 2. CASE PRESENTATION

This is a 68-year-old male with a past medical history of atrial fibrillation on rivaroxaban, hypertension, chronic nonsteroidal anti-inflammatory medication (NSAID) for back pain,

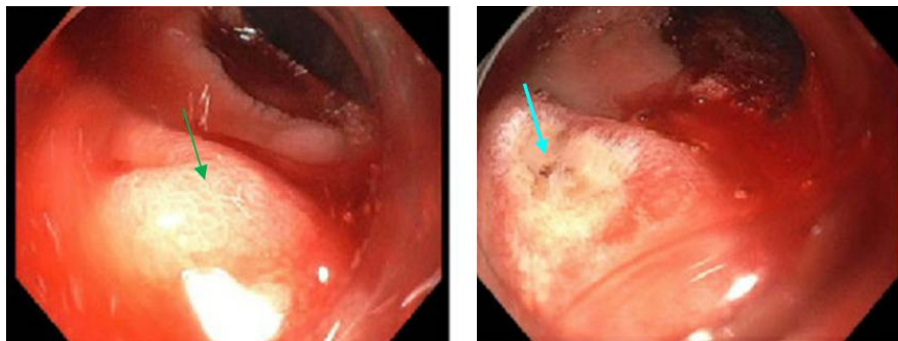
presented with dizziness, nonbloody nonbilious vomiting and multiple episodes of hematochezia. On arrival, his vitals are, blood pressure 156/73 mmHg, heart rate 125 bpm, temperature 37.4 C, and saturating 99% on room air. On examination, the patient had orthostatic hypotension. Laboratory values were significant for Prothrombin (PT) 26.2 seconds, International normalized ratio (INR) 2.28, hemoglobin 10.6 g/dL (no known baseline), white blood cells  $12.5 \times 10^9/L$  with 79% neutrophil percent, blood urea nitrogen 61 mg/dL and creatinine 1.59 mg/dL. Computed Tomography Angiogram (CTA) of abdomen and pelvis revealed active extravasation into the duodenum from a branch of the gastroduodenal artery (Fig. 1).

Patient was started on a proton pump inhibitor (PPI) drip, rivaroxaban was stopped, given 2 units of packed red blood cells (PRBC), and was admitted to Intensive Care Unit (ICU) for further monitoring. In the ICU, he continued to have multiple episodes of hematochezia and hemoglobin dropped to 7.9 g/dL. He received another 3 units of PRBCs and 2 units of fresh frozen plasma (FFP). Patient underwent emergent esophagogastroduodenoscopy (EGD) which revealed a single Dieulafoy lesion (DL) with active bleeding found in the second portion of duodenum (Fig. 2a, 2b).

The bleeding was successfully addressed with injection with epinephrine, cauterization with bipolar probe, and placement of hemostatic clip. The rest of the EGD findings of the esophagus was unremarkable. Hemoglobin levels were stable after the procedure, and the patient was discharged on PPI twice daily and restarted on rivaroxaban seven days after the EGD. At four-week outpatient follow up, patient remained stable without any signs of gastrointestinal bleed.



**Fig. 1. Active extravasation (green arrow) from the gastroduodenal artery into the second part of duodenum**



**Fig. (2a-2b). 2a. Large tortuous Dieulafoy's lesion identified (green arrow) 2b. Dieulafoy's lesion in the second position of duodenum with active bleeding (blue arrow)**

### 3. DISCUSSION

“DLs are abnormally dilated and exposed blood vessels located in the submucosal layer of the gastrointestinal tract that protrude through a small puncture in the overlying normal mucosal tissue” [2]. “Although DLs are a rare cause of gastrointestinal bleeding [4], they can result in significant morbidity and mortality”. The majority of DLs are located on the lesser curvature of the stomach, while those within the duodenum only constitute 15% of cases. Identifying and treating a bleeding duodenal DL can be challenging, often requiring multiple endoscopic attempts. This paper reports the case of a patient who experienced massive GI bleeding from a single DL found in the second portion of the duodenum. The patient underwent an EGD, and the bleeding DL was successfully treated on the first attempt.

Bleeding from DLs is typically painless and can present with various symptoms depending on the location. Duodenal DLs are mostly associated with hematemesis, whereas jejunal DLs present with melena [5]. Our patient presented with nonbloody emesis and multiple episodes of hematochezia. The presence of hematochezia suggests rapid blood loss from the duodenal DL, with brisk movement throughout the small and large colon. The extent of blood loss is further supported by the positive physical exam finding of orthostatic hypotension. Orthostatic hypotension is often seen with blood volume loss of at least 15%. Supine hypotension would indicate a blood volume loss of at least 40%, which was not present in our patient. Therefore, it is likely that the patient experienced between 15-40% loss of blood volume, which required a total transfusion of five units of PRBCs within half

a day. It is important to note that the patient's risk of bleeding was further increased by their chronic use of NSAIDs and rivaroxaban.

“Given the risk factor of chronic NSAIDs use, it is essential to distinguish between DLs and peptic ulcers. DLs are often found in patients with a history of NSAIDs use, and concomitant peptic ulcer disease is reported in 11% of patients” [6]. “Histologically, DLs are characterized by normal mucosa without inflammatory cell infiltration, although biopsies are rarely relied upon clinically” [1]. “DLs can be identified through endoscopic parameters which include: 1) the presence of active arterial spurting or micropulsative streaming from a small mucosal defect or through the surrounding normal mucosa; 2) visualization of a protruding vessel, with or without active bleeding, within a small mucosal defect or through the surrounding normal mucosa; and/or 3) the presence of fresh, tightly adherent clot(s) that are attached to a small mucosal defect or normal appearing mucosa at a narrow point” [7]. “However, identifying and treating bleeding duodenal DLs can be challenging due to the small size of the lesion, normal-appearing mucosa, and intermittent nature of the bleeding” [1]. “The patient's DL lesion was successfully identified and treated on the first endoscopic attempt with the aid of CTA, which detected active extravasation from the branch of the gastroduodenal artery. Most cases with bleeding from DLs undergo emergent evaluation by colonoscopy or endoscopy” [5]. While the use of angiography, red cell scanning, and capsule endoscopy is questionable due to the sporadic character of the bleed [1], angiography was essential in identifying the location of the bleed and providing important information for the endoscopist. Therefore, the bleeding DL was recognized within one endoscopic attempt.

“Before 1990, mortality rates from DLs were high and surgical treatment was often necessary [8]. Since then, endoscopic treatments such as injection of epinephrine, rubber band ligation, hemoclips, bipolar electrocoagulation, and laser therapy have been developed” [1]. “Among these, epinephrine injection combined with a heat probe is considered the optimal treatment method for duodenal DLs” [9]. “However, newer studies suggest that band ligation and hemocliping are superior to injection therapy for not only controlling the bleed but also preventing recurrent bleeding” [10]. In this case, we utilized a combination of epinephrine injection, heat

probe, and hemocliping to control the active bleeding from the duodenal DL in our patient. We believe that this combination of endoscopic therapies contributed to the successful control of the active bleeding DL and further prevention of rebleeding in our patient.

#### 4. CONCLUSION

Recognizing the different causes of gastrointestinal (GI) bleeding is crucial for prompt and effective management. However, bleeding from Dieulafoy's lesions (DLs) is often overlooked and has been associated with high mortality rates. While DLs in the duodenum are rare, they can be often controlled with multiple attempts of endoscopy. Our paper highlights the importance of imaging before undergoing endoscopy, particularly if the patient is clinically stable, to increase the likelihood of successful first-attempt management of the bleeding DL.

#### CONSENT

Informed consent was obtained from the patient for publication of this case report.

#### ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

#### COMPETING INTERESTS

Authors have declared that no competing interests exist.

#### REFERENCES

1. Yilmaz TU, Kozan R. Duodenal and jejunal Dieulafoy's lesions: optimal management. *Clin Exp Gastroenterol.* 2017;10:275–83. Available: <https://doi.org/10.2147/CEG.S122784>.
2. Morowitz MJ, Markowitz R, Kamath BM, von Allmen D. Dieulafoy's lesion and segmental dilatation of the small bowel: an uncommon cause of gastrointestinal bleeding. *J Pediatr Surg.* 2004;39:1726–8. Available: <https://doi.org/10.1016/j.jpedsurg.2004.07.027>.
3. Sai Prasad TR, Lim KH, Lim KH, Yap T-L. Bleeding jejunal Dieulafoy pseudopolyp: capsule endoscopic detection and laparoscopic-assisted resection. *J*

- Laparoendosc Adv Surg Tech A. 2007;17:509–12.  
Available: <https://doi.org/10.1089/lap.2006.0063>.
4. Chaer RA, Helton WS. Dieulafoy's disease. J Am Coll Surg. 2003;196:290–6.  
Available: [https://doi.org/10.1016/S1072-7515\(02\)01801-X](https://doi.org/10.1016/S1072-7515(02)01801-X).
  5. Baxter M, Aly EH. Dieulafoy's lesion: current trends in diagnosis and management. Ann R Coll Surg Engl. 2010;92:548–54.  
Available: <https://doi.org/10.1308/003588410X12699663905311>.
  6. Norton ID, Petersen BT, Sorbi D, Balm RK, Alexander GL, Gostout CJ. Management and long-term prognosis of Dieulafoy lesion. Gastrointest Endosc. 1999;50:762–7.  
Available: [https://doi.org/10.1016/s0016-5107\(99\)70155-0](https://doi.org/10.1016/s0016-5107(99)70155-0).
  7. Stark ME, Gostout CJ, Balm RK. Clinical features and endoscopic management of Dieulafoy's disease. Gastrointest Endosc. 1992;38:545–50.  
Available: [https://doi.org/10.1016/s0016-5107\(92\)70513-6](https://doi.org/10.1016/s0016-5107(92)70513-6).
  8. Veldhuyzen van Zanten SJ, Bartelsman JF, Schipper ME, Tytgat GN. Recurrent massive haematemesis from Dieulafoy vascular malformations--a review of 101 cases. Gut. 1986;27:213–22.  
Available: <https://doi.org/10.1136/gut.27.2.213>.
  9. Schmulewitz N. Dieulafoy lesions: a review of 6 years of experience at a tertiary referral center. Am J Gastroenterol. 2001;96:1688–94.  
Available: [https://doi.org/10.1016/S0002-9270\(01\)02485-6](https://doi.org/10.1016/S0002-9270(01)02485-6).
  10. Chung IK, Kim EJ, Lee MS, Kim HS, Park SH, Lee MH, et al. Bleeding Dieulafoy's lesions and the choice of endoscopic method: comparing the hemostatic efficacy of mechanical and injection methods. Gastrointest Endosc. 2000;52:721–4.  
Available: <https://doi.org/10.1067/mge.2000.108040>.

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