Gurvitis syndrome: the dark shade of hematemesis

A 63-year-old man who was a chronic smoker presented with a 12-hour history of hematemesis, increased abdominal girth, and weight loss (5 kg in the previous month). His medical history included biopsy-proven tubular adenocarcinoma liver metastases of unknown origin, which had been diagnosed 9 months prior to presentation and was treated with a 5-month course of chemotherapy with nanoparticles of gemcitabine and cisplatin as part of a clinical trial. Two months prior to presentation, the patient underwent two sessions of FOLFIRI (folinic acid, fluorouracil, irinotecan) as second-line chemotherapy. There was no history of corrosive intake or alcohol in the past. At admission the patient was hypotensive, with palpable liver margin and ascites. Blood work was modified as shown in ▶ Table 1. Abdominal ultrasound showed ascites, liver metastasis, and splenomegaly. Esophagastroduodenoscopy showed AEN, circumferential black discoloration with sharp distal transition to normal mucosa at the gastroesophageal junction, starting from the superior esophageal sphincter (▶ Fig. 1), which was more severe in the distal third of the esophagus (▶ Video 1), and a bulbar ulcer. Esophageal biopsies were not done, as these are not required for diagnosis [2].

The patient was kept nil-per-os, started on aggressive resuscitation with intravenous fluids, and given proton-pump inhibitor and broad-spectrum antibiotics. His condition did not improve, with acute liver failure and severe coagulopathy (international normalized ratio 6.8), worsened neurological status, hypoglycemia, and finally death by cardiorespiratory arrest after 4 days. Mortality rate is high (30%–50%) and related to severe co-morbidities, as the death rate due to AEN is only 6% [3, 4].

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Competing interests

None
The authors

Cătălina Diaconu1,2, Mihai Ciocîrlan2,3, Mădălina Ilie1,2, Vasile Sandru1, Daniel Vasile Balaban2,4, Oana Plotoea1,2, Mirea Diculescu5,5

1 Department of Gastroenterology, Clinical Emergency Hospital Bucharest, Bucharest, Romania
2 "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania
3 Department of Gastroenterology, Agrippa Ionescu Hospital, Bucharest, Romania
4 Department of Gastroenterology, Carol Davila Central Military Emergency University Hospital, Bucharest, Romania
5 Department of Gastroenterology, Fundeni Clinical Institute, Bucharest, Romania

Corresponding author

Mihai Ciocîrlan, MD, PhD
Department of Gastroenterology, "Agrippa Ionescu" Hospital, Ion Mincu no 7, PC 011356, Bucharest, Romania
ciocirlanm@yahoo.com

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