Dieulafoy’s lesion is a tiny submucosal defect overlying an artery in the muscularis mucosa [1]. Dieulafoy’s lesion of the colon is a rare cause of lower gastrointestinal bleeding [2].

A 63-year-old woman with multiple myeloma underwent autologous bone marrow transplantation and after 6 weeks developed massive hematochezia with hemodynamic instability. Colonoscopy demonstrated bright red blood in the terminal ileum, all of the colon, and the rectum (Fig. 1).

After the area had been washed with water, a point of spurting active bleeding was located in the ascending colon. We injected epinephrine and the bleeding stopped; identification of a minute mucosal defect was then possible (Fig. 2).

We complemented the treatment with argon plasma coagulation (APC) using a 2.3-mm probe, with flow rate of 1.0 L/minute and a setting of 40 W in order to minimize the risk of bowel perforation, until the lesion was completely coagulated. Submucosal injection of epinephrine has a protective effect when using thermal techniques in the right colon [3]. There was no rebleeding during the follow-up of 14 days. The patient died after this period from septic shock.

Dieulafoy’s lesion in the setting of hemorrhagic shock has a high risk of rebleeding, justifying the addition of a complementary endoscopic treatment (thermal or mechanical) following epinephrine injection [4–5]. However, we have to keep in mind that the right colon has a thinner wall compared with the stomach, and use of band ligation and heat probe with high temperatures can lead to bowel perforation.

To our knowledge, this is the first report of a combined endoscopic approach with injection of epinephrine and APC to treat a Dieulafoy’s lesion of the right colon in a patient with significant thrombocytopenia. It seems to be a secure and effective modality of endoscopic therapy of bleeding in this setting, with minimum risk of perforation and high possibility of hemostasis.

J. L. S. Souza
Department of Gastroenterology, Diagnostic Center in Gastroenterology, University of Sao Paulo, Brazil

References

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Corresponding author
J. L. S. de Souza, MD
Department of Gastroenterology, Diagnostic Center in Gastroenterology, University of Sao Paulo
255 Dr Enéas de Carvalho Aguiar Ave.
9th floor – Room 9159
São Paulo
Brazil
Fax: +55-11-30697940
jlssebba@gmail.com