Duodenal vascular ectasia (DUVE) associated with hematopoietic stem cell transplant

A 63-year-old man post hematopoietic stem cell transplantation (HSCT) developed significant gastrointestinal bleeding with melena and drops in hemoglobin that required multiple blood transfusions. He had received fludarabine and busulfan for pretransplantation conditioning. Esophagogastroduodenoscopy (EGD) on day 89 post transplantation (+89) revealed an antral-limited portal hypertensive gastropathy (PHG) and duodenopathy that involved the bulb and second part of the duodenum; the findings were also compatible with gastric antral vascular ectasia (GAVE) (Fig. 1). Several subsequent EGDs due to ongoing blood loss all confirmed antral limited PHG. Severe hemorrhagic gastritis and duodenitis consistent with GAVE (Fig. 2) was seen on day +132. The final endoscopy (day +203) showed GAVE throughout the stomach and duodenum, gastric varices, and small esophageal varices. The genesis of these varices was cryptogenic as there was no evidence of either portal hypertension or a splenic vein thrombosis. Treatment for the patient included intravenous/per oral proton pump inhibitors and one treatment of argon plasma coagulation, which did not affect the ongoing blood loss significantly. A transjugular, intrahepatic portosystemic shunt was placed (day +231) due to recurrent bleeding. Unfortunately, the patient died due to overwhelming sepsis and continued bleeding (day +253). Duodenal biopsies from earlier in the admission were re-visited post mortem and felt to be consistent with vascular ectasia (Fig. 3). We present the second reported case of a patient with GAVE and duodenal vascular ectasia (DUVE) associated with HSCT. GAVE is usually limited to the antrum and rarely involves either the duodenum or jejunum [1,2]. It classically appears as red spots or patches in a linear or diffuse collection endoscopically [3]. Risk factors for HSCT-associated GAVE include male sex and exposure to busulfan in the conditioning regimen [4] both present in our patient. DUVE is rare, even following HSCT, but must be considered in the setting of gastrointestinal hemorrhage.

**Competing interests:** None

**S. E. Congly**, **Z. H. Gao**, **M. Storr**

1 Department of Medicine, Division of Gastroenterology, University of Calgary, Calgary, Alberta, Canada
2 Department of Pathology and Laboratory Medicine, University of Calgary, Calgary, Alberta, Canada
References


Bibliography
Endoscopy 2011; 43: E197–E198
© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author
M. Storr
Department of Medicine
Division of Gastroenterology
University of Calgary
3280 Hospital Drive
6th Floor, TRW Building
Calgary
Alberta
Canada T2N 4Z6
Fax: 403-592-5090
mstorr@ucalgary.ca