Delayed perforation 10 days after endoscopic hemostasis using hemostatic forceps for a bleeding Dieulafoy lesion

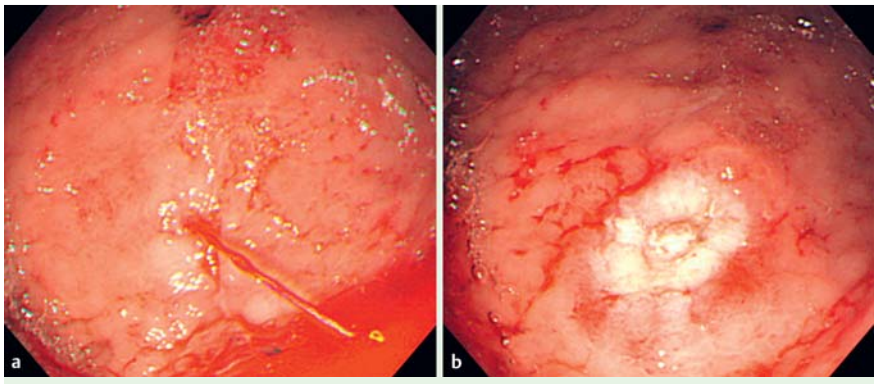

Fig. 1 Emergent endoscopic examination after hematemesis in an 83-year-old man who had undergone treatment for early gastric cancer. **a** Dieulafoy lesion is located at the greater curvature of the gastric remnant with arterial bleeding. **b** The bleeding point was coagulated with hemostatic forceps using the soft coagulation mode at 80 W.

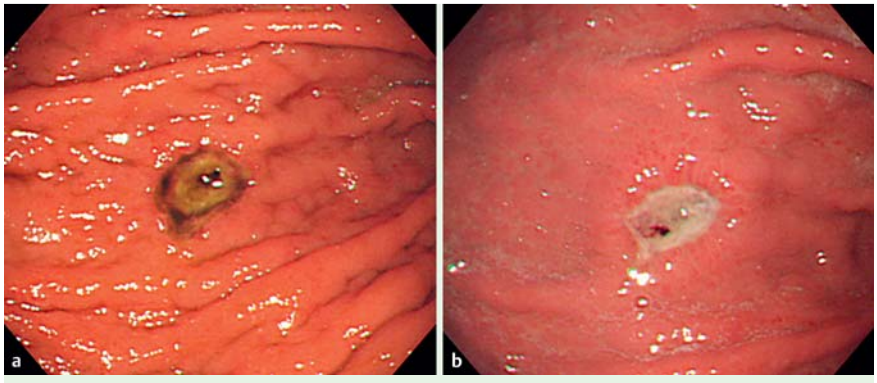

Fig. 2 Follow-up endoscopic view showing absence of delayed bleeding and perforation at the hemostatic site on days 3 (**a**) and 7 (**b**) post hemostasis.

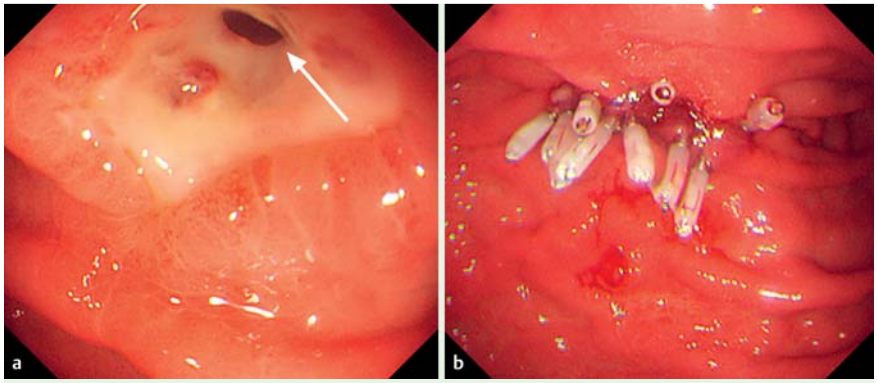

Fig. 3 Emergent endoscopy 10 days after hemostasis. **a** A 3-mm perforation is visible in the hemostatic ulcer (arrow). **b** The perforation closed with nine endoclips.

To our knowledge, there have been no reports in the English literature of cases of delayed perforation occurring more than 2 days after hemostasis for gastrointestinal bleeding, including bleeding related to endoscopic submucosal dissection. Additionally, according to previous reports [1,2], in patients with delayed perforation, surgery was often required to improve their clinical course. We report a rare case of successful conservative treatment for delayed perforation occurring 10 days after endoscopic hemostasis using hemostatic forceps for a bleeding Dieulafoy lesion.

An 83-year-old man was admitted to our hospital for the treatment of early gastric cancer. The patient underwent pylorus-preserving gastrectomy and lymph node dissection. On postoperative day 26, he had massive hematemesis. Emergent endoscopy showed a bleeding Dieulafoy lesion at the greater curvature of the gastric remnant (**Fig. 1a**). The bleeding point was grasped and coagulated with hemostatic forceps (Coagrasper, FD-410LR; Olympus, Tokyo, Japan), using the soft coagulation mode at 80 W (**Fig. 1b**). Follow-up endoscopic examinations showed no evidence of delayed bleeding at the hemostatic site on days 3 and 7 after the hemostasis procedure (**Fig. 2**). However, on day 10 after hemostasis, the patient complained of severe upper abdominal pain. Free air and ascites were seen in the peritoneal cavity on emergent computed tomography and endoscopic examination revealed a perforation of 3 mm in diameter in the hemostatic ulcer (**Fig. 3a**). The perforation was closed endoscopically with nine endoclips (HX-600-090L; Olympus) (**Fig. 3b**). The general condition of the patient as well as the laboratory data and radiographic findings gradually improved, and 40 days after the perforation he was discharged.

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Competing interests: None

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