

Obscure gastrointestinal bleeding due to small-bowel phlebectasias

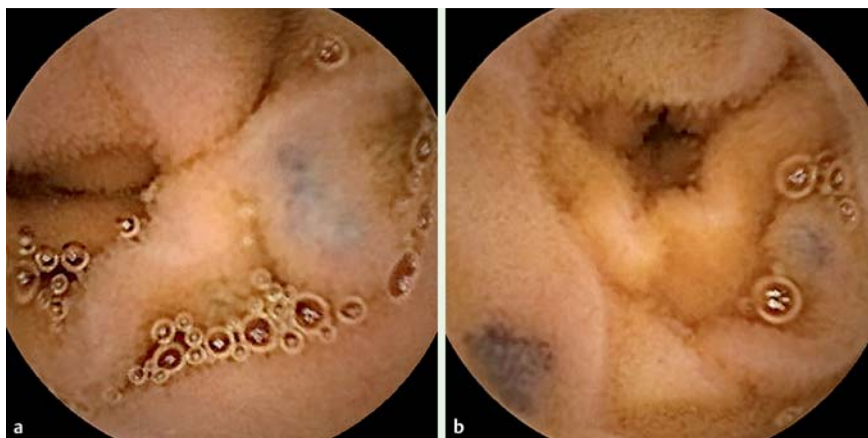


Fig. 1 Capsule endoscopy images in an 80-year-old woman showing multiple large, bluish venous ectasias of the jejunum/ileum, with no signs of active bleeding. The lesions are submucosal, covered by normal epithelium, and vary in size. They look like blackberries embedded within the mucosa.

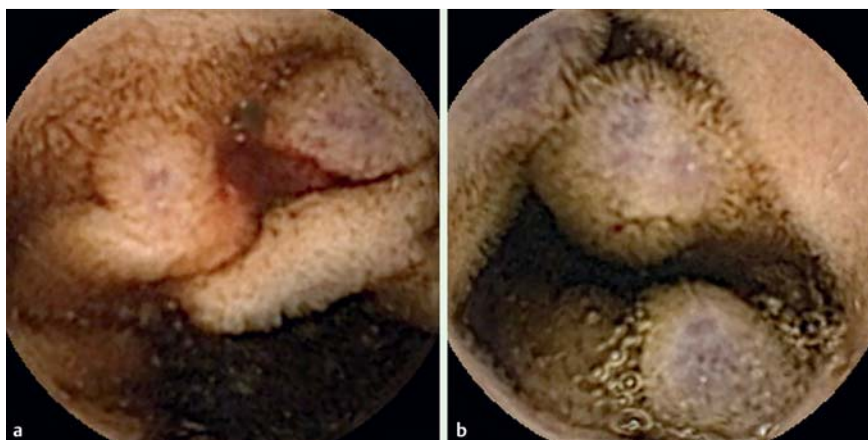


Fig. 2 Capsule endoscopy images in a 66-year-old man showing active bleeding due to multiple large venous ectasias.

Phlebectasias or venous ectasias are rare benign vascular abnormalities of the gastrointestinal tract [1]. They are vascular “malformations” with an abnormal endothelial lining and are thought to be congenital in origin, although the causes and etiological factors responsible for their occurrence are not clear. The lesions are usually asymptomatic; however, occasionally, they may present with gastrointestinal hemorrhage, varying from mild to massive. On endoscopy the lesions appear as bluish submucosal lesions, with a nodular, polypoid, or rarely tumor-like appearance [2].

We present two patients who were found to have small-bowel phlebectasias. The first patient was an 80-year-old woman who presented with obscure occult gastrointestinal bleeding and a hemoglobin level of 10g/dL. Capsule endoscopy (Pillcam SB2; Given Imaging, Yoqneam, Israel) revealed multiple (more than 20) bluish venous ectasias (1–4 mm in size) in the jejunum/ileum, but no signs of active bleeding (● Fig. 1). The patient was treated with oral iron supplements and after 18 months of follow-up her anemia had improved.

The second patient was a 66-year-old man, with a history of coronary artery disease and coronary artery stent placement, who presented with overt obscure gastrointestinal bleeding (melena) and a hemoglobin level of 7.4 g/dL. Capsule endoscopy confirmed active bleeding due to multiple large venous ectasias of the jejunum/ileum (● Fig. 2). Abdominal Doppler ultrasound and computed tomography angiography (CTA) were normal. The patient has been managed conservatively: he has continued to have intermittent melena, but has required a blood transfusion only once.

These cases are of interest because small-bowel phlebectasia has a low prevalence, is under-recognized, and is difficult to treat. The failure to recognize these vascular lesions is likely to be due to the scant endoscopic literature that is available about them. We believe therefore that our description helps to improve the knowledge of the appearance of phlebectasias on capsule endoscopy.

Although there are some possible treatments, such as resection of the affected area of bowel or cyanoacrylate injection, neither of these was chosen in our patients because both had significant small-bowel involvement and as a result, the risks of surgery or subsequent short-bowel syndrome were considered too high. Nonetheless, if bleeding recurs or if anemia becomes more problematic, the benefits of a more aggressive treatment approach may outweigh those of the conservative approach. In any event, capsule endoscopy was essential in achieving the diagnosis of this very rare condition, and the findings spared the patients from undergoing further diagnostic tests.

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Competing interests: None

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