A single-center United States experience with bleeding Dieulafoy lesions of the small bowel: diagnosis and treatment with single-balloon enteroscopy

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Institutions
Institutions are listed at the end of article.

Introduction: A Dieulafoy lesion (DL) of the small bowel can cause severe gastrointestinal bleeding, and presents a difficult clinical setting for endoscopists. Limited data exists on the therapeutic yield of treating DLs of the small bowel using single-balloon enteroscopy (SBE).

Methods: Data were collected from Tampa General Hospital a 1 018-bed teaching hospital affiliated with University of South Florida in Tampa, Florida. Patients were selected from a database of patients that underwent SBE from January 2010 – August 2013.

Results: Eight patients were found to have DL an incidence of 2.6% of 309 SBE performed for obscure gastrointestinal bleeding. 7/8 were identified in the jejunum, with one found in the duodenum. The mean age of patients with DL was 71.5 years old. 6/8 patients were on some form of anticoagulant/antiplatelet agent. The primary modality of therapy employed was electrocautery, multipolar electrocoagulation in seven patients and APC (argon plasma coagulation) in one patient. In three patients, electrocoagulation was unsuccessful and hemostasis was achieved with clip placement. Three patients required repeat SBE with one found to have rebleeding from a failed clip with hemostasis achieved upon reaplication of one clip.

Conclusion: In our United States’ experience, SBE offers a reasonable therapeutic approach to treat DL of the small bowel with low rates of rebleeding, no adverse events, and no patient requiring surgery.
finally made identification of the culprit lesion, responsible for chronic or acute bleeding in the small bowel, possible in a less invasive manner [2]. Unfortunately SBCE is only diagnostic and does not allow biopsies or treatment. Balloon assisted enteroscopy (BAE) using either a single or double-balloon technique opened the door for possible visualization of the entire small bowel tract with the ability to treat or biopsy previously unreachable areas. When both anterograde and retrograde routes are used successively, a “total” enteroscopy has been reported in up to 86% of patients [3]. However, more modest rates have been reported in three randomized controlled trials where complete enteroscopies reportedly ranged from 0% to 22% in SBE and 18.5% to 66% in DBE (RR, 1.73; 95%CI, 0.86 – 3.48; P=0.12) [4 – 6].

Dieulafoy lesion (DL) is a recognized cause of gastrointestinal bleeding since the first reported case in the late 1800s [7]. It accounts for up to 5% of all instances of acute upper gastrointestinal bleeds [8]. DLs are found throughout the gastrointestinal tract, but are usually located in the proximal stomach along the lesser curvature. Rarely, these lesions may be found in the small bowel and present an anatomical dilemma secondary to the inability to reach these lesions by esophagogastroduodenoscopy (EGD) or colonoscopy for endoscopic treatment. Previously, small-bowel DL were identified via angiography and treated with either conservative management or surgical resection in cases of massive hemorrhage [9]. However, since the initial case report in 1990 by Goldenberg et al. describing the endoscopic characteristics and management of small bowel DL questions regarding a feasible alternative to surgical therapy have surfaced [10]. Limited data exists regarding enteroscopic treatment for these lesions with only one Austrian experience where ten cases were treated with either a single or double-balloon enteroscopy [11]. In this report we have reviewed our SBE data base to determine the outcomes for patients that were treated for bleeding small-bowel DL since 2010.

Methods

Institutional Review Board approval was obtained from the University of South Florida and Tampa General Hospital. Patients were selected from a database of patients that underwent SBE from January 2010-August 2013 at Tampa General Hospital. Over this time 375 SBEs were performed for patients with suspected or documented small bowel bleeding unreachable with either EGD or colonoscopic modalities. A total of 309 patients underwent SBE with 348 performed anterograde, and 27 retrograde. Forty-two patients required more than one SBE, either bidirectional or repeated in the same direction. We collected information on demographics including: age, sex, comorbidities, smoking, alcohol, and use of anticoagulation/anti-platelet agents or proton pump inhibitor therapy. The diagnostic techniques used before SBE were also recorded including EGD, colonoscopy, push enteroscopy, SBCE, and angiography. The hemodynamic status of each patient was characterized by recording initial heart rate, blood pressure, hemoglobin, and number of units of packed red blood cells transfused over the course of treatment (Table 1).

Treatment

Diagnosis of DL was based on the finding of one of the three following criteria [11]:

1. A spurting artery or micropulsatile artery streaming from either a small mucosal defect or normal surrounding mucosa;
2. Appearance of a fresh, adherent clot with a narrow point of attachment either to a small mucosal defect or to normal surrounding mucosa; or
3. Visualization of a protruding vessel with or without active bleeding within either a small mucosal defect or within normal mucosa.

The choice of hemostasis was left to the preference of the endoscopist. In our population: Either multipolar Gold probe (Boston Scientific, Natick, Massachusetts, United States) or argon plasma coagulation (Erbe Elektromedizin, Tübingen, Germany) was the primary therapeutic modality. When these modalities failed a hemoclip application (Resolution Clip; Boston Scientific, Natick, Massachusetts, United States) was performed.

Data were retrieved from a review of hospital medical records and by contacting patients via telephone. Follow-up was defined as the time between enteroscopic hemostasis and last patient contact, first reblooding episode, or death.

Evaluation

Initial evaluation of all our patients for suspected obscure gastrointestinal bleeding (OGIB) included both an initial EGD and colonoscopy as per current expert panel recommendations [12]. OGIB is defined as “occult or overt bleeding that persists or recurs after an initial negative endoscopic evaluation including colonoscopy and EGD”. Occult OGIB refers to iron deficiency anemia or a positive fecal occult blood test when there is no evidence of visible blood, whereas overt bleeding is categorized as bleeding from the gastrointestinal tract that persist or recurs without an obvious etiology after EGD or colonoscopy.

SBCE was performed to assess the location of the lesion. Patients with a history of inflammatory bowel disease or potential causes of small bowel obstruction were evaluated with a patency capsule study before SBCE. The initial approach to SBE was determined based on the combination of clinical symptoms (i.e. melena vs hematochezia), and results of the SBCE where lesions found in the first 75% of the small bowel were approached anterograde. A retrograde approach was used in cases where lesions were suspected in the distal 25%. If no bleeding was detected on initial enteroscopy, a submucosal tattoo was placed to mark the deepest insertion point, and the other enteroscopic route was performed. In cases where bleeding continued, but no lesion was detected on SBCE, an anterograde approach was used as the initial method of choice. Entire small bowel enteroscopy was not performed if the suspected primary lesion was found and hemostasis was achieved on the initial enteroscopic approach. In cases where reblooding was suspected, the initial diagnostic approach was repeated so repeat endoscopic therapy could be performed when necessary. Interventional radiological embolization or surgical intervention was planned only when endoscopic hemostasis could not be achieved.

Single-balloon enteroscopy

Single-balloon enteroscopy (SBE) systems consists of a high-resolution endoscope (SIF-Q180; Olympus Medical, Center Valley, Pennsylvania, United States) with a working length of 200cm, 9.2 mm in diameter, and contains a working channel of 2.8 mm diameter. The disposable overtube (ST-SB1; Olympus Medical) was 140 cm long with a 13.2 mm outer diameter, and was equipped with a latex-free balloon at the tip where air can be inflated and deflated from a pressure-controlled pump system allowing...
for passage through the small bowel [13]. For the anterograde approach, only an overnight fast was used, whereas bowel preparation was used in cases of retrograde SBE. SBE was performed by one of four experienced endoscopists. All eight cases where DL was identified were treated by a single endoscopist. Sedation with propofol was used for all patients.

Statistical analysis

Descriptive statistics were employed to summarize the demographic data. The success rate associated with use of SBE for bleeding DL was measured as the primary outcome. Duration of follow-up was expressed as the mean follow-up time.

Results

Small bowel DLs were found in eight patients during the study period. Small bowel DLs were found in an elderly population with an overall mean age of 71.5 years. One-half of the patients were male and the predominant race was white (7/8 patients). Most patients were on either anticoagulation or antiplatelet therapy with four patients on at least two anticoagulant/antiplatelet agents (one was on both aspirin and Coumadin, three on aspirin/Plavix), and 6/8 were on at least aspirin. Smoking was prevalent in half, and alcohol use was listed in 2/8, however no patients used these agents together. A history of peptic ulcer disease (PUD) or GERD was listed in 3/8 patients. PPI therapy was used in half, and alcohol use was listed in 2/8, however no patients were involved in the study. Patients demonstrate oozing on initial diagnostic SBE (Table 2).

All patients experienced overt OGB and reported melena on initial examination. All patients underwent EGD, colonoscopy, and SBCE before SBE. One patient had push enteroscopy before SBE and another had a prior angiogram with failed arterial embolization. The mean time from the onset of symptoms until performance of SBCE was 60.6 days (range, 4–150; median, 30) and the mean time between SBCE and the diagnostic/therapeutic SBE was 75.9 days (range, 12–210; median, 30). In all cases, the SBCE was performed before the referral for SBE. There were no reports of angioectasia in any of the SBCE studies. The initial mean hemoglobin found in the DL population was 7.0 gm/dL (range, 5.3–9.3). All patients required packed red blood cell transfusions with the average use of 6.6 units (range, 3–14) required during hospitalization. All patients that were found to have DL underwent anterograde SBE with 7/8 lesions found in the jejunum and one found in the fourth portion of the duodenum. Active bleeding was observed in 6/8 patients; two of the patients demonstrate oozing on initial diagnostic SBE (Table 2).

The primary modality of therapy employed was electrocautery, multipolar electrocoagulation in seven patients and APC in one (Fig. 1a, 1b and Fig. 2a, 2b). Epinephrine injection was used as an adjuvant therapy to initially slow bleeding in two patients. In three patients, electrocoagulation was unsuccessful and hemostasis was achieved with clip placement (resolution clips) (Video 1 and Video 2). The average hospitalization for overt OGB secondary to DL was 7.8 days (range, 2–27). The mean follow-up time for patients diagnosed with DL was 17.5 months (range, 1.5–44). Three patients required repeat SBE with one found to have rebleeding from a failed clip. Two patients requiring repeat SBE were treated initially with bipolar/clip (one pa-

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**Table 1** Patient hemodynamic profiles.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Race</th>
<th>Comorbidities</th>
<th>Anticoagulant/Platelets</th>
<th>PPI</th>
<th>Smoking</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>86</td>
<td>Men</td>
<td>W</td>
<td>CABG, HTN, Afib with PPM, Bladder Cancer, Gastritis</td>
<td>ASA, Coumadin</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>73</td>
<td>Women</td>
<td>W</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>63</td>
<td>Men</td>
<td>W</td>
<td>MI, CABG, CHF, Afib; HTN, AS, CVA, OSA</td>
<td>ASA, Plavix</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>81</td>
<td>Men</td>
<td>W</td>
<td>CABG, CHF, PPI, Afib, HTN, AVR</td>
<td>ASA, Plavix</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>69</td>
<td>Women</td>
<td>W</td>
<td>GERD, PUD (non-bleeding), duodenal stenosis, benign colon polyps</td>
<td>ASA</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>60</td>
<td>Women</td>
<td>W</td>
<td>PUD, anemia, COPD</td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>60</td>
<td>Women</td>
<td>Other (Trinidad)</td>
<td>MI, CHF, HTN, HLD, DM, Anemia</td>
<td>ASA</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>80</td>
<td>Men</td>
<td>W</td>
<td>MI, CHF, AS, MR/ TR, Afib, HTN, CVA</td>
<td>ASA, Plavix</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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**Table 2** Demographic characteristics of patients undergoing single-balloon enteroscopy.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Race</th>
<th>Comorbidities</th>
<th>Anticoagulant/Platelets</th>
<th>PPI</th>
<th>Smoking</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>86</td>
<td>Men</td>
<td>W</td>
<td>CABG, HTN, Afib with PPM, Bladder Cancer, Gastritis</td>
<td>ASA, Coumadin</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>73</td>
<td>Women</td>
<td>W</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>63</td>
<td>Men</td>
<td>W</td>
<td>MI, CABG, CHF, Afib; HTN, AS, CVA, OSA</td>
<td>ASA, Plavix</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>81</td>
<td>Men</td>
<td>W</td>
<td>CABG, CHF, PPI, Afib, HTN, AVR</td>
<td>ASA, Plavix</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>69</td>
<td>Women</td>
<td>W</td>
<td>GERD, PUD (non-bleeding), duodenal stenosis, benign colon polyps</td>
<td>ASA</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>60</td>
<td>Women</td>
<td>W</td>
<td>PUD, anemia, COPD</td>
<td>None</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>60</td>
<td>Women</td>
<td>Other (Trinidad)</td>
<td>MI, CHF, HTN, HLD, DM, Anemia</td>
<td>ASA</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>80</td>
<td>Men</td>
<td>W</td>
<td>MI, CHF, AS, MR/ TR, Afib, HTN, CVA</td>
<td>ASA, Plavix</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
tient treated with four clips and the second with one clip), and the third patient initially treated with epinephrine/bipolar therapy. The patient treated with four clips was found to have rebleeding occurring two weeks after the initial SBE and achieved hemostasis with reapplication of one clip. Repeat SBE was performed at two months and four months in patient five, however no rebleeding was noted at the tattooed area where the previous DL was identified. Patient number 8 had noted rebleeding 44 months post initial anterograde SBE; a subsequent anterograde SBE was negative for bleeding, and bleeding resolved with conservative management (Table 3 and Table 4).

**Table 3** Patient diagnostic and outcome data.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Diagnostic modality</th>
<th>Location</th>
<th>DBE/ SBE</th>
<th>Approach</th>
<th>Enteroscopy (#)</th>
<th>Treatment (#)</th>
<th>Finding</th>
<th>AVM anywhere in gastrointestinal tract</th>
<th>Re-bleed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>E/C/SBCE/ IR</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>2</td>
<td>Bipolar/APC/Clip (1)</td>
<td>Active bleeding</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>E/C/SBCE</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>1</td>
<td>Bipolar</td>
<td>Spurring</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>E/C/SBCE</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>2</td>
<td>Bipolar/Epi/Clip (2)</td>
<td>Active bleeding</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>E/C/SBCE</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>1</td>
<td>Bipolar</td>
<td>Active bleeding</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>E/C/SBCE</td>
<td>4th portion duodenum</td>
<td>SBE</td>
<td>A</td>
<td>3</td>
<td>Bipolar/Clip (1)</td>
<td>Oozing</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>E/C/SBCE/ push enteroscopy</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>2</td>
<td>Bipolar/Clip (4)</td>
<td>Oozing</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>E/C/SBCE</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>1</td>
<td>APC</td>
<td>Active bleeding</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>E/C/SBCE</td>
<td>Jejunum</td>
<td>SBE</td>
<td>A</td>
<td>2</td>
<td>Epi/Bipolar</td>
<td>Active bleeding</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**Abbreviations:** DBE, double-balloon enteroscopy; SBE, single-balloon enteroscopy; AVM, arteriovenous malformation; E, esophagogastroduodenoscopy; C, colonoscopy; SBCE, wireless small-bowel capsule endoscopy; IR, interventional radiology embolization; A, anterograde; APC, argon plasma coagulation; Epi, epinephrine injection.

**Video 1**

Dieulafoy lesion (DL) identified during single-balloon enteroscopy in the mid jejunum. Initially, the lesion was actively bleeding with a steady stream of blood in the absence of an identifiable mucosal ulceration or angioectasia. After identification, the lesion was treated successfully using multipolar electrocauterization.

**Online content including video sequences viewable at:** www.thieme-connect.de

**Video 2**

Dieulafoy lesion (DL) identified during single-balloon enteroscopy in the jejunum. Initially, the lesion was oozing with an adherent clot. After initial treatment with argon plasma coagulation therapy the lesion began to bleed actively, but with further treatment bleeding ceased.

**Online content including video sequences viewable at:** www.thieme-connect.de
Table 5  Incidence of small-bowel Dieulafoy lesion and obscure gastrointestinal bleeding.

<table>
<thead>
<tr>
<th>Study</th>
<th>DL (#)</th>
<th>Capsule positive</th>
<th>Incidence (%)</th>
<th>Anterograde</th>
<th>Duodenum (#)</th>
<th>Jejunum (#)</th>
<th>Ileum (#)</th>
<th>SBE (#)</th>
<th>DBE (#)</th>
<th>&gt;2 endoscopy sessions before diagnosis</th>
<th>Re-bleedes (#)</th>
<th>Follow-up (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landaeta, et al, 2013 [22]</td>
<td>17</td>
<td>N/A</td>
<td>7.2</td>
<td>12/17</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
<td>1</td>
<td>Median, 9</td>
</tr>
<tr>
<td>Chen et al, 2010 [23]</td>
<td>4</td>
<td>N/A</td>
<td>2.6</td>
<td>4/4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>Mean, 8.8</td>
<td></td>
</tr>
<tr>
<td>Prachayakul et al, 2013 [24]</td>
<td>5</td>
<td>N/A</td>
<td>4.31</td>
<td>5/5</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Paliwal et al, 2011 [25]</td>
<td>5</td>
<td>3/4</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4–12</td>
</tr>
</tbody>
</table>

**Table 4  Patient follow-up information.**

**Table 5  Incidence of small-bowel Dieulafoy lesion and obscure gastrointestinal bleeding.**

**Discussion**

DL lesions are now a well-recognized etiology of upper gastrointestinal bleeding with frequencies ranging from 0.5% to 14% [14–17]. DL may be found throughout the gastrointestinal tract from esophagus to the colon [9, 18,19], however, their distribution is uneven. Most occur in the stomach with (61% to 82%) found in the proximal one-third, and up to 98% found in the upper stomach, predominantly on the lesser curvature [20,21]. Small-bowel DL first appeared in the literature in 1978 with two patients treated surgically for jejunal lesions [9]. However, cases with similar histology reported as “aneurysms” of the small bowel have been reported since 1944 [7]. In one systematic review, the mean percentage of DL located in the small bowel was 16% (duodenum, 15%; jejunum-ileum, 1%). The incidence of small-bowel DL as a cause of OGIB is sparsely reported (Table 5) [11, 22–26]. In patients undergoing BAE, the incidence of small-bowel DL is reported to range from 2.6% to 7.2% [11, 22–24]. Our incidence of 2.6% is similar to the current literature, however, these may be vast underestimates as misidentified, non-bleeding DL, or those not reachable with BAE may lead to an underdiagnoses. The small mucosal defect often present and intermittent bleeding nature found in some DL may also contribute to underdiagnoses, or explain at least a portion of idiopathic cases of OGIB after negative BAE. One retrospective review of patients undergoing evaluation for OGIB found an incidence of 1.32% (3/227) small-bowel DL in patients undergoing SBCE that were later diagnosed on BAE [27]. Similar to our experience, the predominant location of small-bowel DL in several case series or retrospective reviews with BAE appears to be the jejunum (range 80% to 100%) [11, 23–25].

Endoscopic management for general DL includes: banding, clipping, electrocautery, cyanoacrylate glue, sclerosant injection, epinephrine injection, heater probe, and laser therapy [28]. Epinephrine injection monotherapy is associated with higher rates of recurrent rebleeding [16], but may be useful in combination to slow bleeding and optimize visualization of the lumen for thermal/mechanical therapy. Studies have shown that mechanical endoscopic methods such as hemoclip and band ligation are more effective than injection and thermal therapy for general DL located predominantly in the stomach [29–33]. The optimal treatment approach for small-bowel DL has not been reported in any large scale study. Based on our experience, mechanical clipping may be the therapy of choice since it was successful in three cases where thermal methods failed, and in patient one where a prior interventional radiological embolization failed to stop bleeding.

Bleeding from small-bowel DL may be life threatening [34,35], and before 1990 was treated surgically. Goldenberg first reported a case of bleeding duodenal DL successfully treated with epinephrine injection therapy and electrocoagulation [10]. Sporadic case reports and case series have since surfaced reporting success with BAE [11,22–26]. In our population, either bipolar or APC therapy was used as initial therapy of choice. When these modalities failed a hemoclip was placed. This approach provided initial hemostasis in all eight patients. Initial hemostasis without rebleeding was 87.5% (7/8) in our series using SBE as our primary therapeutic modality and eventually reached 100% without any patients proceeding to surgery. Dulic-Lakovic et al reported rebleeding in 3/10 patients undergoing BAE (2/7 DBE, 1/3 SBE) with 2/10 patients eventually requiring surgical intervention [11].
Chronic intermittent bleeding maybe encountered when treating small-bowel DL resulting in multiple BAEs before diagnosis. Dulic-Lakovic et al. reported 4/10 requiring at least two or more BAEs before diagnosis [11]. The diagnostic yield in patients undergoing first look endoscopy varies in gastric DL with reports ranging from 63% to 92% [2, 36, 37]. From our experience with small-bowel DL all patients were diagnosed on initial SBE. The usefulness of repeating BAE after an initial negative BAE should be determined based on index of suspicion, previous diagnostic testing results, and the hemodynamic profile of each individualized patient.

The profile of our patients diagnosed with small-bowel DL included a group that was predominantly elderly (mean age, 71.5 years), and had multiple cardiac comorbidities 5/8 (62.5%). A few case series of small-bowel DL treated with BAE reported a similar experience where mean ages of 69.7 and 77 years were reported although data on cardiovascular risk factors and anticoagulation/antiplatelet/NSAID use were unavailable [11,23,38]. Small-bowel DL does exist in younger patients. A study of 17 patients, median age 54 years (range, 15–80), reported a 15 year old treated for a small-bowel DL [22]. Cardiac comorbidities and use of antiplatelet/coagulation/NSAID have not been studied as a risk factor for small-bowel DL. Gastric DL studies have reported the prevalence of cardiovascular disease, diabetes, or chronic renal disease as high as 90% in patients found to have bleeding gastric DL [28]. Likewise the use of medications affecting coagulation has ranged from 28% to 51% of cases identified as gastric DL [16, 28, 36, 39]. Whether our high incidence of cardiac comorbidities occurred by chance, and whether the NSAID/antiplatelet use is related to an elderly population at risk for cardiac comorbidities/arthritis remains to be determined with larger studies.

Limitations of our experience include the small cohort of patients diagnosed with DL and the retrospective study design. However, our experience adds to the very limited data on small-bowel DL in the literature, and is the first US reported experience with an extended follow-up. We also have reported a more descriptive patient profile, and have demonstrated that SBE has been an effective treatment modality in patients found to have DL (100% success) in addition to reviewing the current literature on this topic.

**Conclusion**

Misidentified, intermittent non-bleeding DL, or those not reachable with BAE may lead to an underdiagnoses and may explain at least a portion of idiopathic cases of OGIB. Therefore, we recommend an early aggressive approach with BAE after initial negative colonoscopy/EGD, or in cases where a high index of suspicion exists to ensure identification and treatment. The usefulness of repeating BAE after initial negative BAE should be determined based on clinical suspicion, previous diagnostic testing results, and the hemodynamic profile of each patient. In our U.S. experience, SBE offers a reasonable therapeutic approach to treat DL of the small bowel with a low rates of rebleeding, no adverse events, and no patient going on to require surgery.

**Competing interests:** None

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**References**
disorders according to their clinical manifestations: a retrospective re-
view. BMC Gastroenterol 2013; 13: 103
25 Paliwal M, Madan K et al. Small bowel Dieulafoy’s: diagnosis, manage-
ment and outcome. J Gastroenterol Hepatol 2011; 26: 249 Abstract
26 Chung CS, Huang CT, Wang HP et al. Single-balloon enteroscopy for the 
management of a bleeding Dieulafoy lesion in the jejunal diverticulum. 
27 Ciobanu L, Pascu O, Diaconu B et al. (2013) Bleeding Dieulafoy’s-like le-
sions of the gut identified by capsule endoscopy. World J Gastroenterol 
2013; 19: 4823 – 4826
28 Norton ID, Petersen BT, Sorbi D et al. Management and long-term prog-
29 Chung IK, Kim EJ, Lee MS et al. Bleeding Dieulafoy’s lesions and the 
choice of endoscopic method: comparing the hemostatic efficacy of 
mechanical and injection methods. Gastrointest Endosc 2000; 52: 
721 – 724
30 Park CH, Sohn YH, Lee WS et al. The usefulness of endoscopic hemoclip-
31 Alis H, Oner OZ, Kalayci MU et al. (2009) Is endoscopic band ligation su-
perior to injection therapy for Dieulafoy lesion? Surg Endosc 2009; 23: 
1465 – 1469
32 Hwang JH, Fisher DA, Ben-Menachem T et al. The role of endoscopy in 
the management of acute non-variceal upper GI bleeding. Gastrointest 
Endosc 2012; 75: 1132 – 1138
33 Katsinelos P, Paroutoglou C, Mimiatis K et al. (2005) Endoscopic treat-
ment and follow-up of gastrointestinal Dieulafoy’s lesions. World J 
Gastroenterol 2005; 11: 6022 – 6026
34 Veldhuyzen van Zanten SJ, Bartelsman JF, Schipper ME et al. Recurrent 
massive haematemesis from Dieulafoy vascular malformations– a re-
view of 101 cases. Gut 1986; 27: 213 – 222
35 Mumtaz R, Shaukat M, Ramirez FC. Outcomes of endoscopic treatment 
of gastrointestinal Dieulafoy’s lesion with rubber band ligation and 
36 Juler GL, Lubitzke HG, Lamb R et al. The pathogenesis of Dieulafoy’s gas-
37 Skok P. Endoscopic hemostasis in exulceratio simplex-Dieulafoy’s dis-
38 Dy NM, Gostout CJ, Balm RK. Bleeding from the endoscopically-identi-
fied Dieulafoy lesion of the proximal small intestine and colon. Am J 
Gastroenterol 1995; 90: 108 – 111
39 Kasapidis P, Georgopoulos P, Delis V et al. Endoscopic management and 
long-term follow-up of Dieulafoy’s lesions in the upper GI tract. Gas-
trointest Endosc 2002; 55: 527 – 531