



Image of the Month

A very rare case of upper gastrointestinal bleeding: A Dieulafoy's lesion on a duodenal gastrointestinal stromal tumor

Daniela Scimeca, Filippo Mocchiari*, Elisabetta Conte, Roberto Di Mitri

Gastroenterology and Endoscopy Unit, A.R.N.A.S. Civico-Di Cristina-Benfratelli H, Palermo, Italy



A 69 year-old male was admitted due to severe upper gastrointestinal bleeding requiring packed erythrocytes transfusions. The emergency upper endoscopy showed in the 2nd duodenum an active spurting bleeding from the surface of a bulge with smooth appearance, likely to refer to an intraluminal subepithelial lesion (Fig. 1A), suspected for gastrointestinal stromal tumor (GIST). The lesion had a normal overlying mucosa with a bleeding point, clearly visible after continuous washing (Fig. 1B, arrow), compatible with a Dieulafoy's lesion. During a temporary interruption of the bleeding (Fig. 1C) an endoclip was placed to close the lesion (Fig. 1D), without resumption of bleeding in the following minutes of obser-

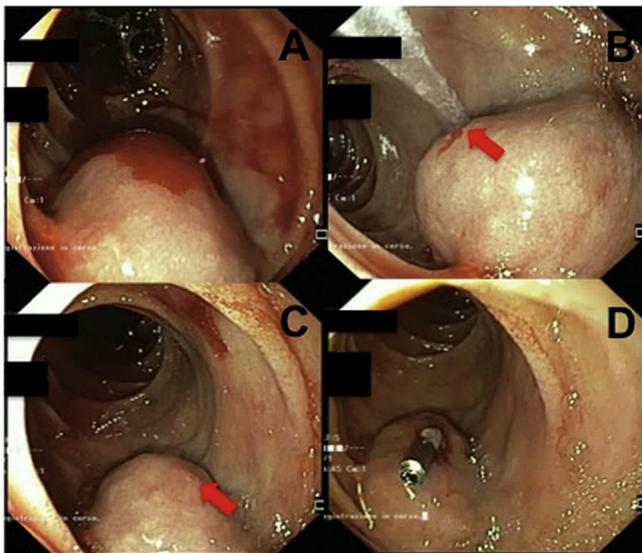


Fig. 1. A) active spurting bleeding from the surface of a duodenal bulge; B–C) normal overlying mucosa with bleeding point compatible with a Dieulafoy's lesion (arrows); D) endoclip placed to close the lesion.

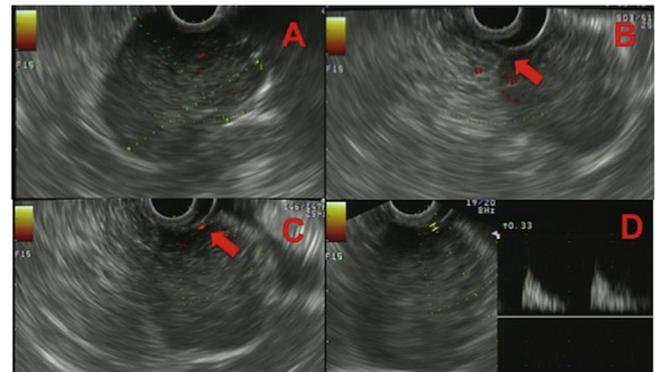


Fig. 2. A–B) endoscopic ultrasound view of the suspected GIST originating from the tonaca muscularis propria (arrow); C) superficial small submucosal vessel visible at the power-doppler examination (arrow); D) arterial profile of the submucosal vessel at flowmetry to refer to the previous Dieulafoy's lesion.

vation. One week later an endoscopic ultrasound using a linear probe was performed to characterize the subepithelial lesion and showed a 35 mm roundish lesion with hypoechoic inhomogeneous pattern and well-defined margins (Fig. 2A), originating from the fourth layer (tonaca muscularis propria) of the intestinal wall (Fig. 2B, arrow). At the power-doppler examination, a small submucosal vessel (Fig. 2C, arrow), with an arterial profile (peak systolic and end-diastolic velocities) at flowmetry (Fig. 2D) was visualized in correspondence with an anechoic superficial area to refer to the previous Dieulafoy's lesion. Considering the typical ultrasonographic aspect of GIST of the duodenal lesion and the recent hemorrhagic complication, the patient was referred to surgery for resection.

Conflict of interests

None declared.

* Corresponding author.

E-mail addresses: d.scimeca80@gmail.com

(D. Scimeca), fmocchiari@gmail.com (F. Mocchiari), e.conte03@gmail.com (E. Conte), robdimitri68@gmail.com (R. Di Mitri).