An unusual case of lower gastrointestinal hemorrhage: ileocecal mucosal bleeding

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Background

• Twenty to 30% of patients presenting with major gastrointestinal bleed will have a source distal to Ligament of Trietz.

• Differential diagnosis[4] of lower GI bleed commonly includes diverticulosis, arteriovenous malformations, ischemic colitis, colorectal neoplasms, radiation proctitis, anorectal disorders, and post-polypectomy bleeding.

• Ileocecal mucosal bleeding is an undocumented and rare cause of lower gastrointestinal bleeding.

Patient Presentation

This is a 73-year-old woman with end stage renal disease and paroxysmal atrial fibrillation on apixaban who presented after three days of having maroon stool which progressed to hematochezia. On presentation, patient endorsed weakness and fatigue resulting in missed hemodialysis. She was normotensive with mild sinus tachycardia. On physical examination, her abdomen was soft, non-tender, and non-distended; her initial rectal examination was significant for maroon stool and external hemorrhoids. Laboratory studies demonstrated acute on chronic anemia (hemoglobin of 5.6 gm/dL) and electrolyte derangements reflective of missed dialysis.

Clinical Course

Hospital Course: Patient was admitted and dialyzed. Bleeding progressed from maroon stools to frank hematochezia. She required 5 Units of packed red blood cell transfusions, and ultimately underwent endoscopic evaluation on hospital day 3. Colonoscopy revealed a localized area of active, mucosal bleeding at the ileocecal junction without evidence of dieulafoy lesion, ulcer, mass, arteriovenous malformation, or diverticula. Hemostasis was achieved with epinephrine injection and the use of bipolar electrocautery. She was later resumed on her therapeutic anticoagulation without recurrence of bleeding, and discharged on hospital day 4.

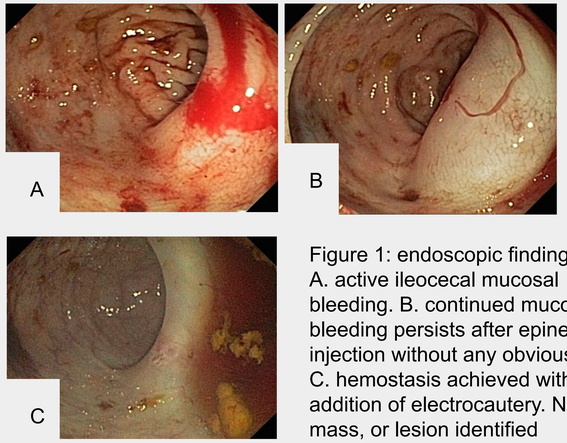


Figure 1: endoscopic findings. A. active ileocecal mucosal bleeding. B. continued mucosal bleeding persists after epinephrine injection without any obvious cause C. hemostasis achieved with addition of electrocautery. No ulcer, mass, or lesion identified

Discussion

• This case expands the differential of massive lower gastrointestinal bleeding to include ileocecal mucosal bleeding - a likely transient, cause that is amenable to endoscopic management with epinephrine and electrocautery.
• While there have been reported cases of cecal dieulafoy lesions[2] and other submucosal masses[1], this endoscopic evaluation did not identify any gross cause of bleeding other than the mucosa
• The patient's mucosal bleeding was identified in the setting of
  ◦ Uremic platelet dysfunction[3]
  ◦ Therapeutic anticoagulation, apixaban
• Clinical Significance: mucosal bleeding is a rare, transient cause of gastrointestinal hemorrhage that must be actively ongoing to be endoscopically diagnosed

References

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