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A RARE CASE OF ISOLATED ANGIODYPSPLASIA OF COLON PRESENTING WITH MASSIVE LOWER GI BLEED

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Abstract

Angiodysplasias of the colon are enlarged and fragile blood vessels in the colon result in occasional loss of blood from the lower gastrointestinal tract. It may be observed incidentally at colonoscopy or patients may present with lower gastrointestinal bleeding. The objective of this case report is to highlight a rare case of isolated angiodypsplasia of colon presenting with massive lower GI bleed. 40 yr male presented with severe lower GI Bleed from few hours approximately 2 litres. Haemoglobin was 4 gm and he was requiring high dose ionotropes. Emergency colonoscopy was done which showed around 2 litres of blood in colon with active bleeding point and spurting from hepatic flexure of colon. Emergency laparotomy was done with intra op ENTEROSCOPY to localize the lesion. There was a pinpoint angiodysplasia in the colon which was the source of the bleed. Wide excision of the lesion was done. Patient improved post op and was discharged on POD VI.

Key Words: Angiodysplasias, lower gastrointestinal tract, Emergency colonoscopy, bleeding point.

INTRODUCTION

Angiodysplasias, arteriovenous malformations or angiomas are the commonest vascular lesions of the gastrointestinal (GI) tract. They are enlarged, fragile blood vessels in the colon. It is a common cause of lower GI bleeding in the elderly. It may be asymptomatic and discovered incidentally during colonoscopy. Patients may present with hematochezia, melena, positive occult blood test or iron deficiency anemia. It may present as an isolated lesion or multiple

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vascular lesions. The exact cause of vascular ectasia is not known but it is thought to occur due to ageing and degeneration of blood vessels.

An hypothesis states that it is due to contraction of the muscular layer leading to partial occlusion of the sub-mucosal veins of the intestinal wall, subsequently the veins become tortuous and dilated. It predominantly affects the cecum and right side of the colon. It could also affect any part of the large bowel.

Angiodysplasias have been reported in association with aortic stenosis, chronic renal failure, Von willibrand's disease and cirrhosis of the liver. The incidence of angiodysplasias is 0.8% in healthy people undergoing screening with colonoscopy in the US. The incidence in other parts of the world is not known because of paucity of data.

There is no sex predilection. It is found predominantly in elderly people above the age of 65 years. Diagnosis of angiodysplasias may be made using colonoscopy, angiography, and computed tomography (CT) scan and endoscopic forceps biopsy, which may reveal characteristic histopathologic features of dilated, distorted, thin walled vessels, however they are not generally recommended because of low diagnostic yield and risk of bleeding. Treatment could be conservative, medical, endoscopic or surgical treatment, but because of risk of re-bleeding surgical treatment is thought to be the best modality of treatment. However, treatment should be individualized depending on severity.

CASE REPORT

40 yr male presented with severe lower GI Bleed from few hours approximately 2 litres.

Haemoglobin was 4 gm and he was requiring high dose ionotropes.

Emergency colonoscopy was done which showed around 2 litres of blood in colon with active bleeding point and spurting from hepatic flexure of colon.

Emergency laparotomy was done with intra op ENTEROSCOPY to localize the lesion. There was a pinpoint angiodysplasia in the colon which was the source of the bleed. Wide excision of the lesion was done.

Patient improved post op and was discharged on POD VI.

U can see the active spurter in the below colonoscopy video.

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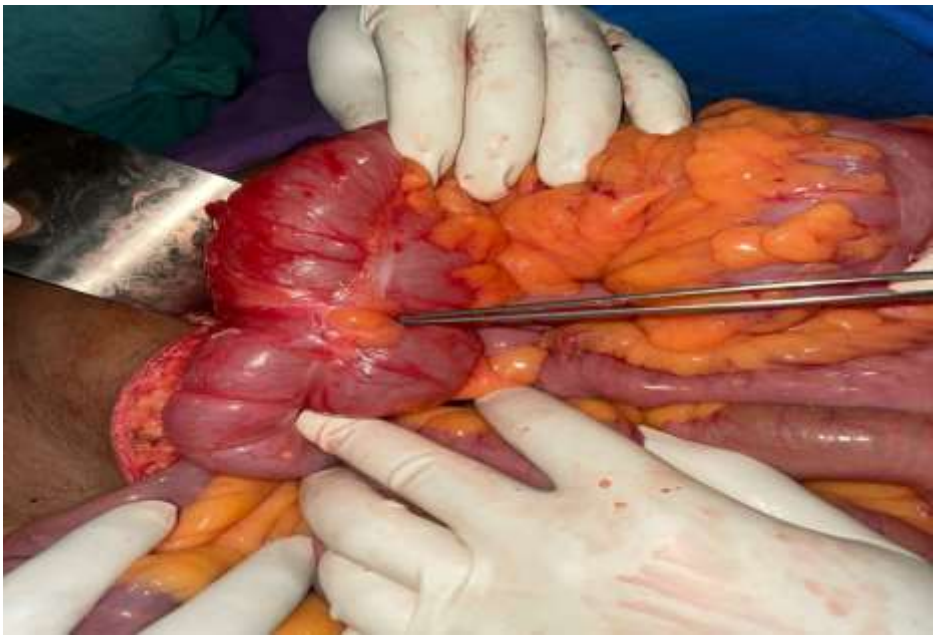

Figure 1: Angio dysplasia in the resected part of colon

Figure 2: Colon sutured after respecting the angiodysplasia

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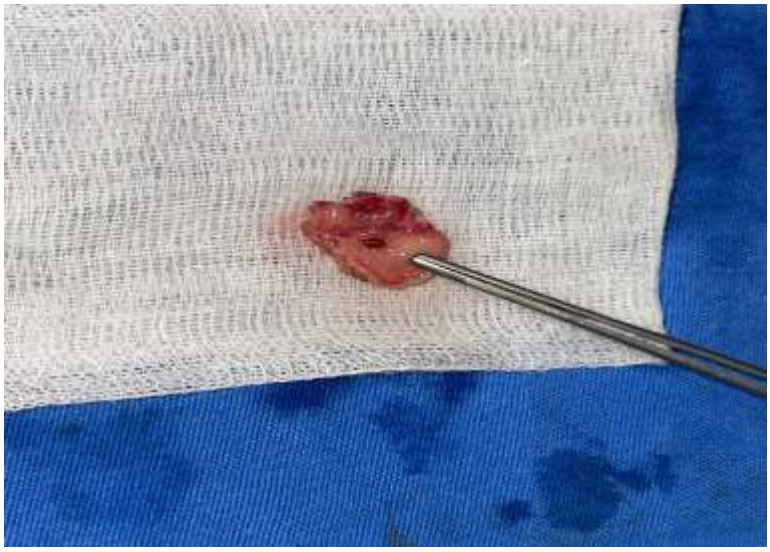

Figure 3: angiodysplasia in the ascending colon having an prominent appendices epiploicae outside

DISCUSSION

Evaluation for gastrointestinal blood loss should be considered in patients with unexplained iron deficiency anemia. Gastric angiodysplasias are an uncommon cause of upper gastrointestinal bleeding. They may be associated with underlying predisposing factors like hereditary hemorrhagic telangiectasia syndrome or undergoing hemodialysis (see Sidebar: Causes of Gastrointestinal Angiodysplasia). They may present with hematemesis, melena, or chronic gastrointestinal blood loss resulting in anemia. Isolated gastric angiodysplasia in young patients, as in our case, are uncommon. In a report of 27 patients with blood loss caused by upper gastrointestinal angiodysplasias, the average age was 71.6 ± 10.2 years. Of these, 7 had underlying cirrhosis, 6 had renal failure, and 1 had hereditary hemorrhagic telangiectasia. Because our patient had angiodysplasia at a young age, we excluded hereditary hemorrhagic telangiectasia by clinical examination and by ruling out other lesions through using capsule endoscopy.

Treatment options include use of endoscopic therapy (argon plasma coagulation [APC] or gastric band ligation), and use of angiographic embolization has been described. Use of drugs like thalidomide (angiogenesis inhibitor), estrogen (promotes vascular integrity and reduces mesenteric blood flow), bevacizumab (antivascular endothelial growth factor), or octreotide (antiangiogenesis, antisecretory, and reduces splanchnic blood flow) may be considered in certain cases.

CONCLUSION

Our case clearly demonstrates the value of evaluating the gastrointestinal tract for any causes of blood loss in patients with unexplained iron deficiency anemia, even in the absence of overt

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episodes of bleeding. Evaluation may include upper gastrointestinal endoscopy, colonoscopy, and small bowel capsule endoscopy, if warranted. The presence of occult blood in stools should also prompt gastrointestinal evaluation. Additionally, our case demonstrates that such evaluation may yield unexpected yet treatable causes like isolated gastric angiodysplasia. Gastric angiodysplasia can be treated using drugs like octreotide or thalidomide. Actively bleeding lesions can be treated with endoscopic APC or banding, and unremitting cases may, on occasion, necessitate surgery.

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