Digestive Endoscopic Corner

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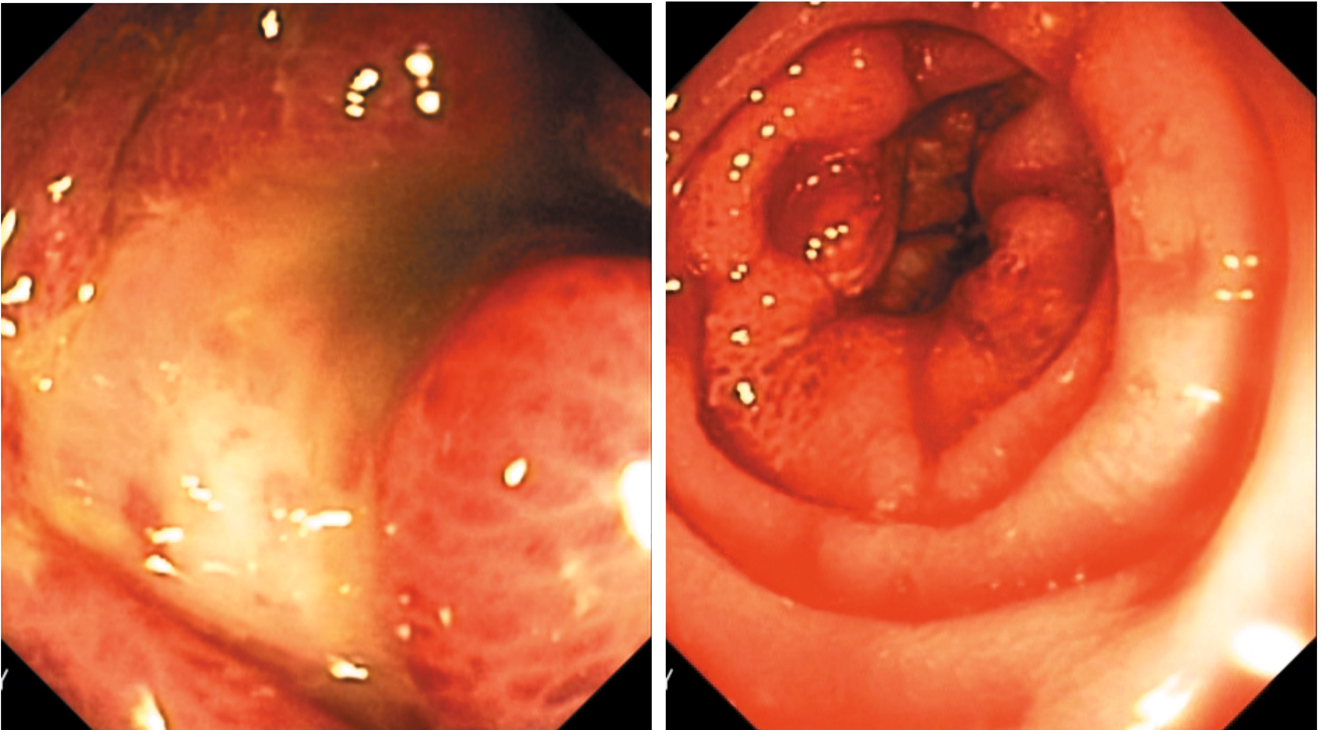
Case 1

A 58 year-old female with history of mitral stenosis and atrial fibrillation. She presented with sudden coliky pain and hematochezia. Colonoscopy was performed. What are the findings? What is the diagnosis?



Answer : There were few small clean base ulcers sized 0.3 cm. each and normal appeared mucosa in the rectum. Diffuse circumferential edema and erythema of mucosa covering with white exudates in descending colon and abrupt transition between the lesion and normal mucosa in the rectosigmoid colon were found.

The diagnosis is ischemic colitis.

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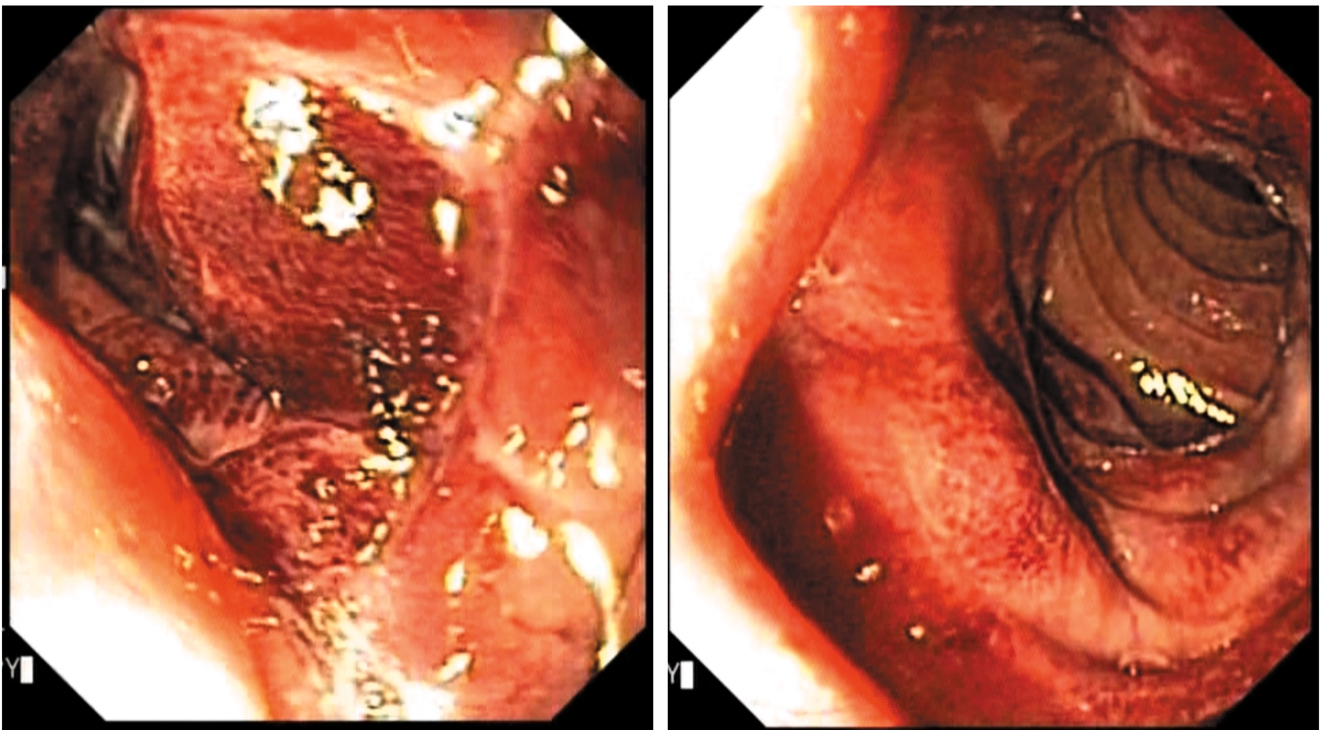
Case 2

A 70 year-old male presented with abdominal pain and hematemesis. He had mitral stenosis and took warfarin 3 mg per day. PT was over 200 seconds on admission. He underwent esophagogastroduodeno-scopy. What are the findings?



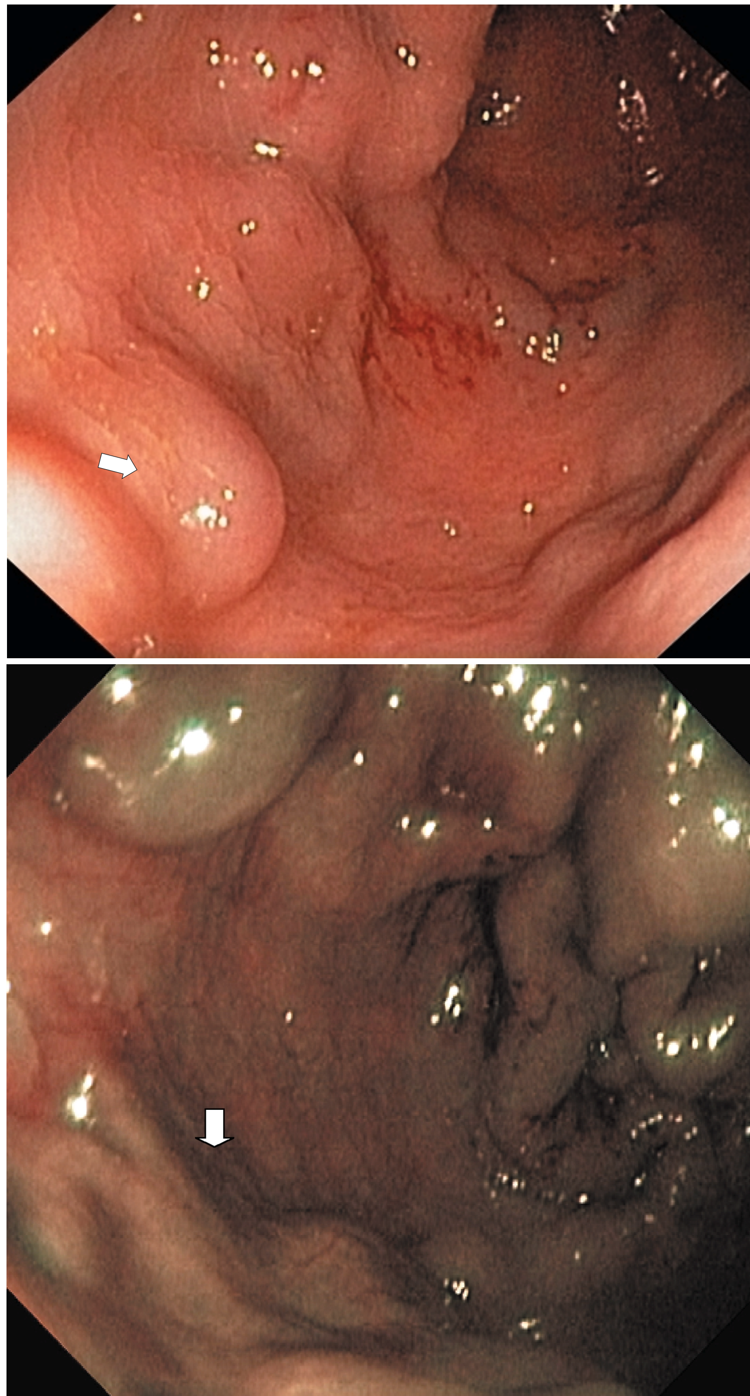
Answer : Erythematous mucosa at prepyloric area and circumferential markedly edematous bluish hemorrhagic mucosa extended from duodenal bulb to the second part of duodenum causing narrowing of lumen were found.

The diagnosis was submucosal duodenal hematoma, most likely from coagulopathy.

The spontaneous intramural hematoma of the small bowel is an uncommon complication of anticoagulant therapy. The site of small bowel involvement is most commonly affected jejunum which accounts for two-thirds of patients (64-69%), followed by ileum (26-38%) and duodenum(10-23%), respectively. The symptoms vary from vague abdominal pain, acute abdomen to intestinal obstruction or gastrointestinal tract bleeding. It should be highly alert to search for this condition in the patients with history of anticoagulants administration who presented with abdominal pain even the INR value is in the therapeutic range. Typical findings in abdominal ultrasonography and computerized tomography can confirm the diagnosis. Medical treatment is the treatment of choice with a good outcome. Surgery should be reserved for cases in which the diagnosis is doubtful and for patients who exhibit signs of bowel necrosis or peritonitis.

Case 3

A 65 year-old male with underlying HBV cirrhosis. He developed recurrent episodes of massive hematochezia. Colonoscopy was performed. What is the diagnosis?



Answer: The diagnosis is rectal varices

Anorectal varices are identified endoscopically in 40% of cirrhotics and should not be confused with hemorrhoids, which are vascular communication of venules and arterioles. They are infrequent causes of bleeding and the aggravating factors are not clearly understood. Hemorrhage tends to occur in more advanced varices such as those with a positive red color sign. No standard treatment for rectal variceal bleeding was established. Successful hemostasis with sclerotherapy, band ligation, transjugular embolization with or without TIPS, and IMV ligation had been reported.