Case report

An Unusual Case Of Upper Gastrointestinal Bleeding

***Qasim L. Abbas**

Case summary:
A 52-year old man was referred to our hospital for further evaluation of one month history of recurrent episodes of upper GI bleeding (hematemesis & melena).Those episodes were recurring every few days with massive hematemesis and melena,necessitating admission to hospital and requiring many units of blood transfusion and esophagogastroduodenoscopy (EGD) done for the patient about 3 times in 2 hospitals before being referred to our center without any obvious lesion, so the patient was labeled as a case of o

bscure upper GI bleeding.The patient was completely well before that and denied any history of alcohol and drug intake or FB (foreign body) ingestion.he was pale, well nourished with no significant abnormal findings on physical examination. His biochemical investigations,apart fro

m low PCV were normal. EGD done for the patient in our hospital which revealed a linear ulcer 2 × 0.5 cm,clean base at the upper third of esophagus (figure 1). on an attempt to take a biopsy from the ulcer edge a foreign body (chicken bone) 3cm long was extracted with biopsy forceps (figure 2). Retrogradely the patient remembered that before his illne

ss he was attending a wedding ceremony and he ate a heavy meal containing chicken. The patient did well after FB removal and bleeding did not recur .

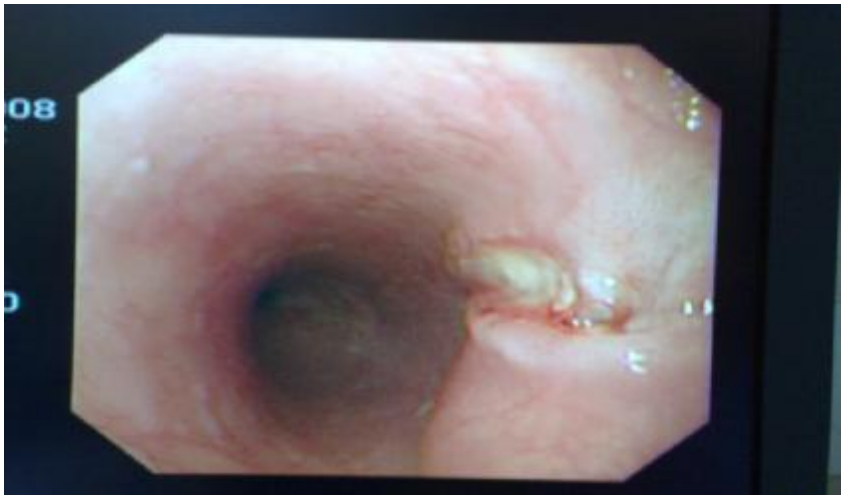

Figure 1: esophageal ulcer

* C.A.B.M,Endoscopy Department, Gastroenterology & Hepatology Teaching Hospital, Medical City, Baghdad

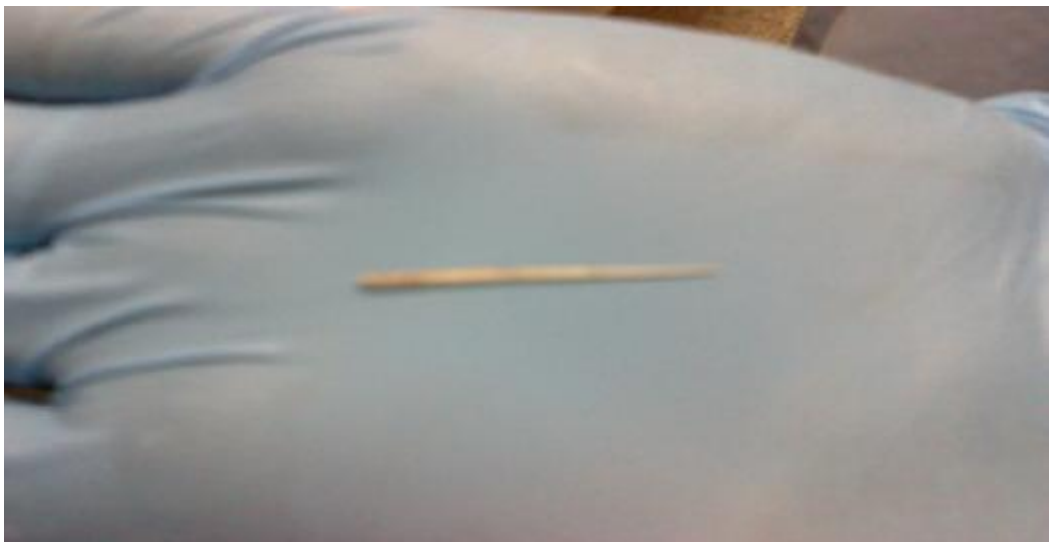

Figure 2 : foreign body(chicken bone)

Discussion:

The two unusual things in this case is that :

First a history of foreign body ingestion is lacking because patient was unaware of ingesting a FB. In communicative adults ,most patients who present with animal or fish bone impactions are symptomatic[1].

Odynophagia and a foreign body sensation often occur with sharp objects and bones, suggesting esophageal mucosal laceration. Ingestions resulting in esophageal obstruction can produce abrupt onset of substernal chest pain, inability to swallow, gagging, vomiting, or a sensation of choking.[2] Drooling and the inability to handle oral secretions suggest a more complete obstruction. Among patients with suspected foreign object ingestion, close to 80% will have a foreign body identified if dysphonia, dysphagia, or odynophagia is present.

However, if patients present with retrosternal pain or pharyngeal discomfort, only 47% will have a foreign body identified.[3] Respiratory compromise may occur with aspiration of secretions or if the object is impacted at or immediately below the upper esophageal sphincter, resulting in compression of the airway.[4] Estimation of the suspected site or level of impaction by the patient is generally not reliable.[5] The one area where patients may be able to accurately localize the object is at the cricopharyngeal muscle, but localization becomes progressively less accurate for distally impacted foreign bodies, with an accuracy of 30% to 40% in the esophagus.[5,6]

Second the interesting thing is a presentation as obscure upper GI bleeding, Obscure upper GI bleeding could be due to lesions that are overlooked in the esophagus, stomach during initial workup which include Cameron's erosions in large hiatal hernias,[7] fundic varices,[8,9] peptic ulcer disease, angioectasias,[7] Dieulafoy's lesion,[10] and gastric antral vascular ectasia.[11,12] Explanations for overlooking a lesion and missing the diagnosis include lesions that have stopped bleeding during endoscopic examination, lesions that are obscured by blood clots that are unable to be mobilized during endoscopy, hypovolemia and significant anemia causing lesions to look less obvious, and intermittent and slow bleeding leading to negative findings on endoscopic and nuclear scans.

Repeat EGD should be undertaken if there is a suspicion of an overlooked lesion, Repeat EGD should be considered in patients with hematemesis and in those taking NSAIDs and the fundus should be carefully examined, with special attention to the site of diaphragmatic hiatus for Cameron's lesion, which remains an underrecognized etiology of obscure GI bleeding. In addition, a transparent cap (band-ligator cap after deploying the bands) fitted to the end of the endoscope may serve as a retractor to examine the blind areas of the upper GI tract, such as the posterior and inferior wall of the duodenum, antrum, high lesser curve, and anastomotic sites, for ulcers and is helpful in uncovering hidden ulcers.[13]

References:

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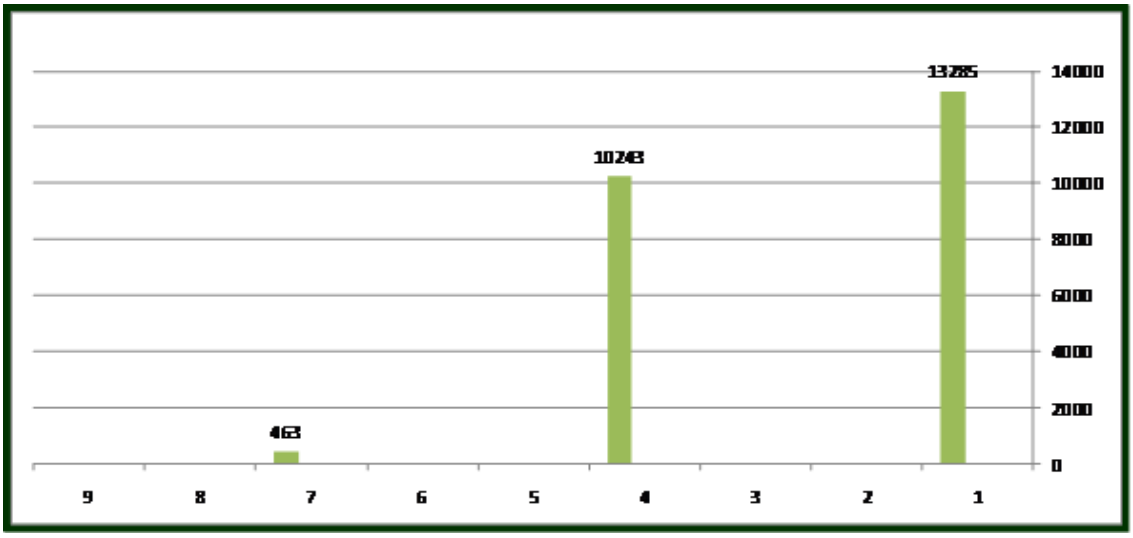
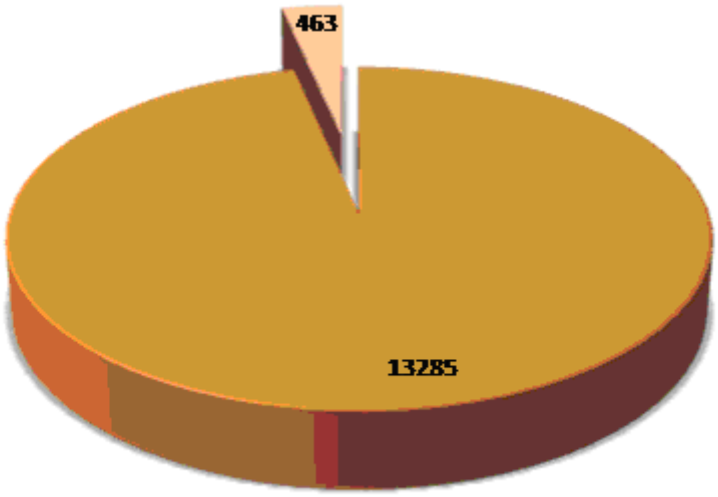
Profile of 2010

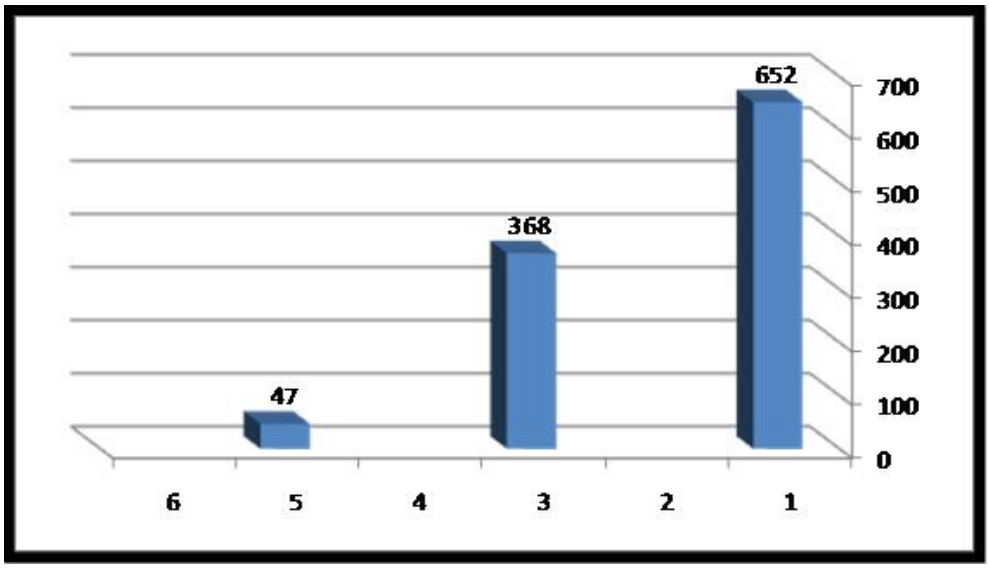
No. of attendants of medical & surgical & pediatric clinic 2010		
Paediarric	surgical	Midical
463	10243	13285



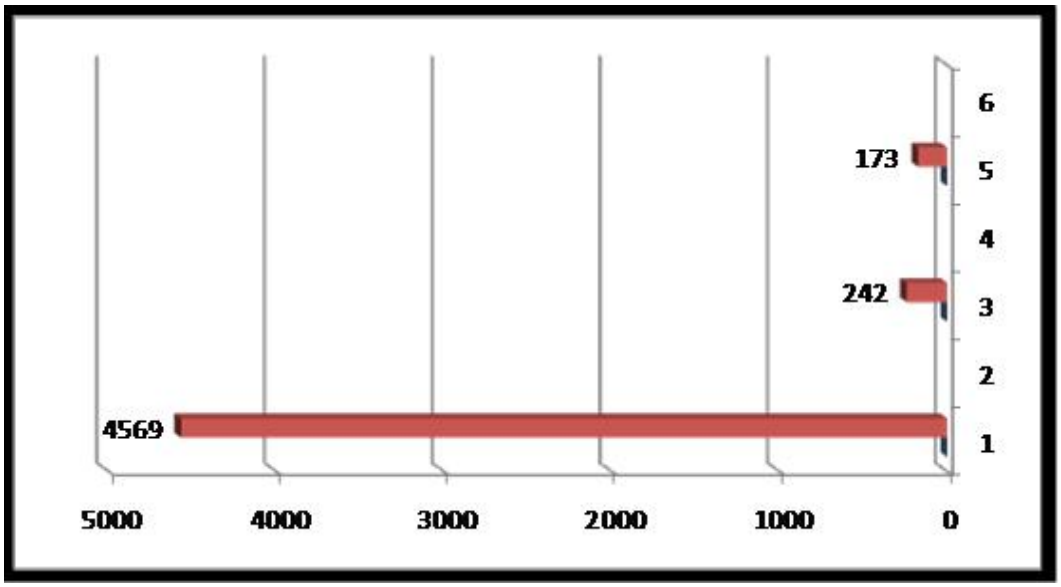
No. of upper & lower endoscopes	
colonoscopy	Endoscopy OGD)
463	13285



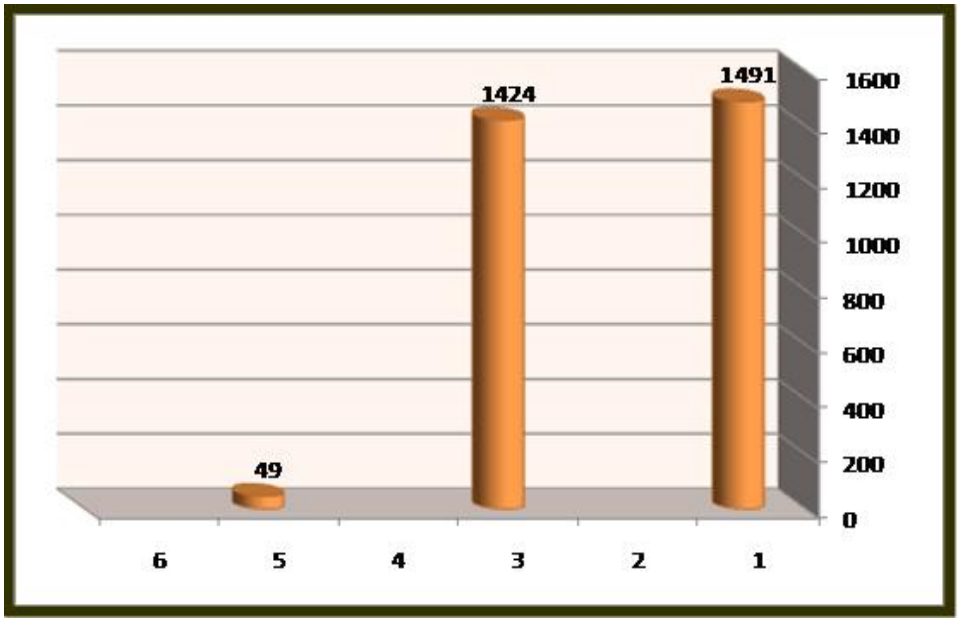
No. of pationets under went RUS,EUS & ERCP 2010		
RUS	EUS	ERCP
47	368	652



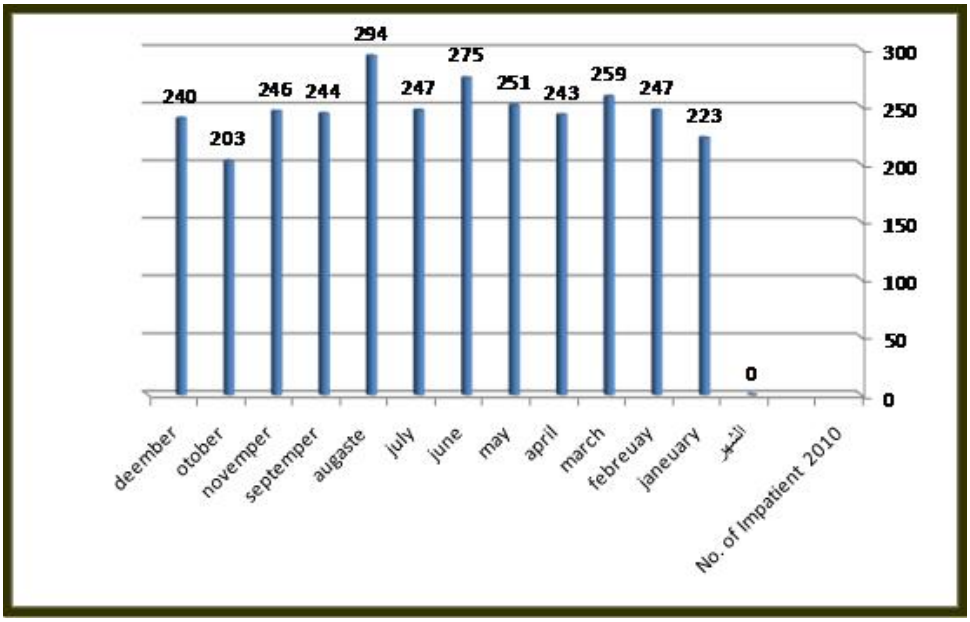
No. of patieant under went abd. U/S ,FNA,Aspiration 2010		
Asperation	FNA	Ultra sound
173	242	4569



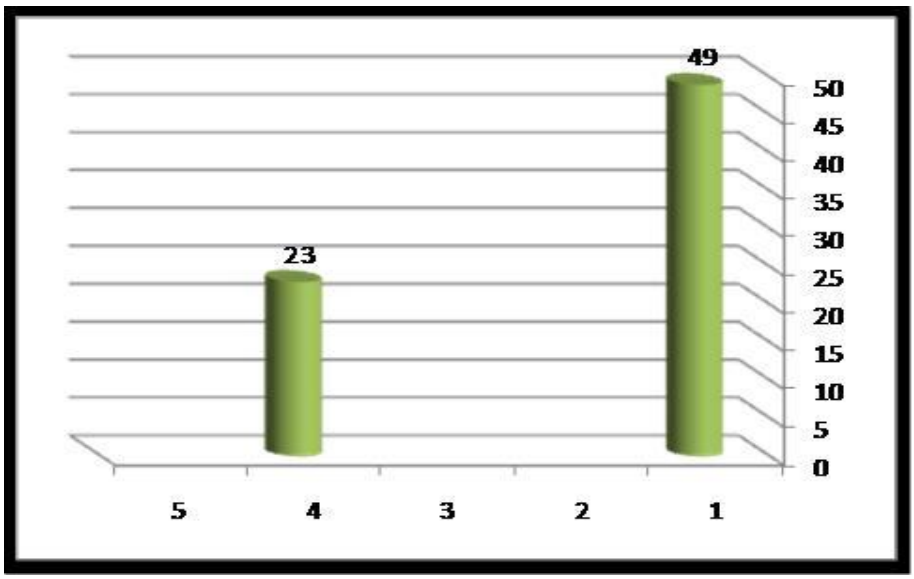
No. of addimision medical & surgical & ICU 2010		
ICU	surgical	medical
49	1424	1491



No. of Inpatient 2010



No. of Mortaliaty rate of male & female patient 2010	
female	male
23	49



No. of super Major ,Major ,Interameddiade & minor operation 2010			
minor	Intramediade	major	Super major
0	1	156	405