A 42-year-old woman admitted for evaluation of hypotension and fainting in the emergency room underwent esophagogastroduodenoscopy because of melena and a hemoglobin concentration of 6.7 g/dL. Endoscopy showed an ulcer 22 × 24 mm in diameter along the anterior duodenal bulb. After the injection of 4 mL epinephrine, the vessel began to bleed massively. Mesenteric angiography was performed urgently. The selective celiac arterial angiogram showed the right and left hepatic arteries arising separately from the celiac trunk. There was also severe vasospasm in the left hepatic artery and gastroduodenal artery (Fig. 1a). No aneurysm was seen because of the severe vasospasm, possibly due to the extravasation. The gastroduodenal artery was embolized with a platinum coil (Fig. 1b). The patient underwent endoscopy a week later, and the duodenal ulcer was seen with the coil located in the intravascular area (Fig. 1c). No active bleeding or oozing was seen, and after stabilization of the hemoglobin concentration the patient was discharged.

A 65-year-old man was admitted to the Ege University chest disease clinic with pneumonia. Esophagogastroduodenoscopy was performed because of massive hematemesis and melena. Significant active bleeding from a giant duodenal ulcer was encountered. Mesenteric angiography was performed urgently in order to undertake embolization of the bleeding artery. On selective angiography after superselective catheterization of the gastroduodenal artery a pseudoaneurysm was observed in the duodenal branch of this main artery (Fig. 2a). Thrombosis of the aneurysm was seen after embolization of the gastroduodenal artery with a platinum coil. No communication and no filling effect of the aneurysm between the collateral branches of the superior mesenteric artery was seen (Fig. 2b). No further bleeding occurred, and the patient was discharged after starting proton-pump inhibitor therapy. Control esophagogastroduodenoscopy was performed 6 weeks later, and the coil was seen protruding into the lumen from the vessel visible at the ulcer site (Fig. 2c).
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Bibliography
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