Delayed perforation 10 days after endoscopic hemostasis using hemostatic forceps for a bleeding Dieulafoy lesion

To our knowledge, there have been no reports in the English literature of cases of delayed perforation occurring more than 2 days after hemostasis for gastrointestinal bleeding, including bleeding related to endoscopic submucosal dissection. Additionally, according to previous reports [1, 2], in patients with delayed perforation, surgery was often required to improve their clinical course. We report a rare case of successful conservative treatment for delayed perforation occurring 10 days after endoscopic hemostasis using hemostatic forceps for a bleeding Dieulafoy lesion.

An 83-year-old man was admitted to our hospital for the treatment of early gastric cancer. The patient underwent pylorus-preserving gastrectomy and lymph node dissection. On postoperative day 26, he had massive hematemesis. Emergent endoscopy showed a bleeding Dieulafoy lesion at the greater curvature of the gastric remnant (Fig. 1a). The bleeding point was grasped and coagulated with hemostatic forceps (Coagrasper, FD-410LR; Olympus, Tokyo, Japan), using the soft coagulation mode at 80 W (Fig. 1b). Follow-up endoscopic examinations showed no evidence of delayed bleeding at the hemostatic site on days 3 and 7 after the hemostasis procedure (Fig. 2). However, on day 10 after hemostasis, the patient complained of severe upper abdominal pain. Free air and ascites were seen in the peritoneal cavity on emergent computed tomography and endoscopic examination revealed a perforation of 3 mm in diameter in the hemostatic ulcer (Fig. 3a). The perforation was closed endoscopically with nine endoclips (HX-600-090L; Olympus) (Fig. 3b). The general condition of the patient as well as the laboratory data and radiographic findings gradually improved, and 40 days after the perforation he was discharged.

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Fig. 1 Emergent endoscopic examination after hematemesis in an 83-year-old man who had undergone treatment for early gastric cancer. a Dieulafoy lesion is located at the greater curvature of the gastric remnant with arterial bleeding. b The bleeding point was coagulated with hemostatic forceps using the soft coagulation mode at 80 W.

Fig. 2 Follow-up endoscopic view showing absence of delayed bleeding and perforation at the hemostatic site on days 3 (a) and 7 (b) post hemostasis.

Fig. 3 Emergent endoscopy 10 days after hemostasis. a A 3-mm perforation is visible in the hemostatic ulcer (arrow). b The perforation closed with nine endoclips.
References


Bibliography
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