ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 11, Issue, 02, pp.1634-1636, February, 2019

DOI: https://doi.org/10.24941/ijcr.34395.02.2019

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

OBSCURE GASTROINTESTINAL BLEEDING IN YOUNG PATIENT - A CASE REPORT

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ARTICLE INFO

Article History:
Received 17th November, 2018
Received in revised form
27th December, 2018
Accepted 19th January, 2019
Published online 28th February, 2019

Key Words:

Obscure Gastrointestinal Bleed (OGIB), Amaurosis, Hematochezia, Endoscopy, Meckel's Diverticulum, Ileocecal Resection.

ABSTRACT

Obscure gastrointestinal (GI) bleeding accounts for approximately 5% of all GI bleeding and is defined as bleeding from an unknown source that persists or recurs after negative endoscopic diagnostic evaluation. We present a case of 21 years old male who was admitted to our hospital with atypical presentation include amaurosis, on and off hematochezia worsen after seafood and alcohol consumption, past medical history showed that he had been treated in different hospitals without improvements, physical examination was uneventful with stable vitals, Endoscopy showed an ulcer with elevated margins and two Lumina in the ileum, and pathological result confirm chronic active inflammation of the mucosa with erosion. His final diagnosis was perforated meckel's diverticulum and ileocecal resection was done and he's currently stable during 6-months follow-up.

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***Citation: Abdi-Samad Abdi Ali, Yu Yan Bo and Iqtida Ahmed Mirza,* 2019.** "Platelet profile in pregnant women with gestational diabetes mellitus", *International Journal of Current Research*, 11, (02), 1634-1636.

INTRODUCTION

Bleeding from the small bowel is uncommon but it is responsible for the majority of patients with gastrointestinal bleeding that persists or recurs without an obvious etiology after upper endoscopy, colonoscopy and possibly radiologic evaluation of the small bowel (Sodhi *et al.,* 2013). In the past, if no source of bleeding was found after an endoscopic evaluation, the bleeding was referred to asbeing "obscure." However, more recently, it has been proposed that the term obscure only beused if patients have not had a source of bleeding identified after a thorough examination of the entire gastrointestinal tract, including the small bowel (David Cave, 2008). Obscure GI hemorrhage we propose in this guideline that the former term referred as obscure GI bleeding (OGIB) be reclassified as small bowel bleeding. The reason for this change in terminology is owing to the fact that the cause of bleeding can now be detected in the majority of patients given advances in small bowel imaging with video capsule endoscopy (VCE), deep enteroscopy, and radiographic imaging. The term OGIB would then be reserved for patients in whom a source of bleeding cannot be identified anywhere in the GI tract and may represent a source of bleeding outside of the small bowel (Lauren Gerson, 2015). Recent advances have led to reclassification of GI bleeding into three categories: upper-, mid-and lower GI bleeding. If the source of GI bleeding is between the ampulla of Vater and the terminal ileum, it is designated as mid-GI bleeding (Lauren *et al.,* 2015; Itay Maza, 2012). Because of an inability to visualize the small bowel properly, patients with a small bowel GI bleed usually end up undergoing multiple diagnostic investigations, requiring multiple hospitalizations and transfusions; therefore, it is necessary to identify the cause and site of hemorrhage accurately, so as to institute appropriate, effective therapy. (Gunjan *et al.,* 2014).

CASE STUDY

A 21year old male referral from other hospital with ileac lesions for more than 9 months had history of blood in stool after alcohol and seafood consumption for about 1800 g, reported tohave history of transient amaurosis for three episodes, he has history of using Proton pump inhibitor prior to index admission, no ingestion of corrosive substances, don't have same history in the family. Past medical history family reported that he had a history of blood in the stool forhis first year of age, which improved with no treatment, later the symptoms recur and has been treated as gastric ulcers at different hospital with no long-standing improvement. Physical examination; young energetic man, not wasted, not pale, not jaundiced, normal hair texture, peripheral lymph nodes were not palpable, no finger clubbing or lower limb edema. temperature was 36.1oc, blood pressure 140/90 mmHg pulse rate was 101beats / minutes regular, normal volume, synchronous and non-collapsing, weight 73kg, height 170 cm. trachea central located, respiratory and cardiovascular examination were unremarkable, Gastrointestinal examination no distended abdomen, no caput medusa, normal bowel

movement and sound, the liver and spleen were not palpable, murphy's sign (-). Laboratory test showed no significant abnormalities detected, sagittal CT showed normal lower abdomen (Figure 4).

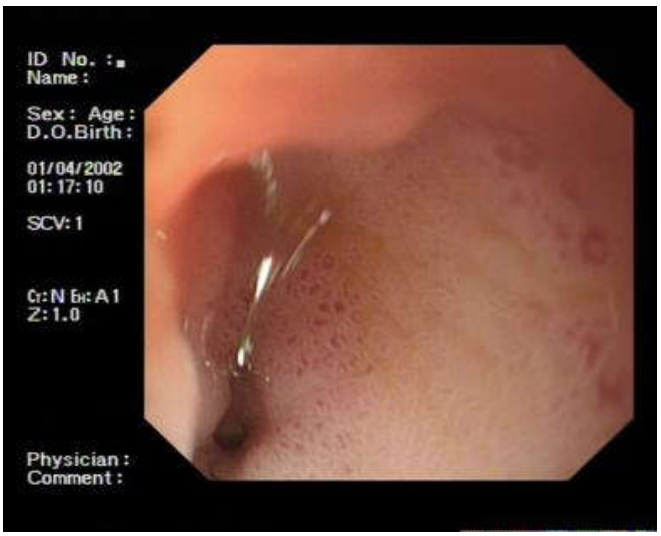

Figure 1. Endoscopy showing visualized apolypoid mass with reddish mucosa without villi

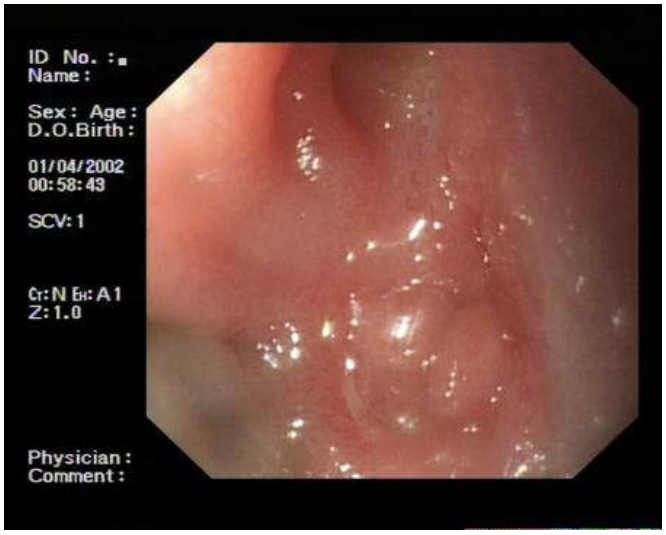

Figure 2. Endoscopic results revealing elevated nodular and polypoid lesions

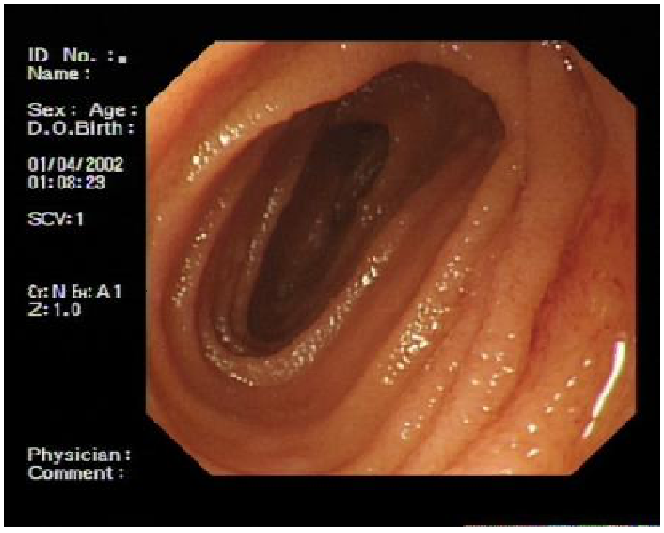

Figure 3. Endoscopic manifestations showing the bridge between small bowel lumen and entrance is thickened with ulceration

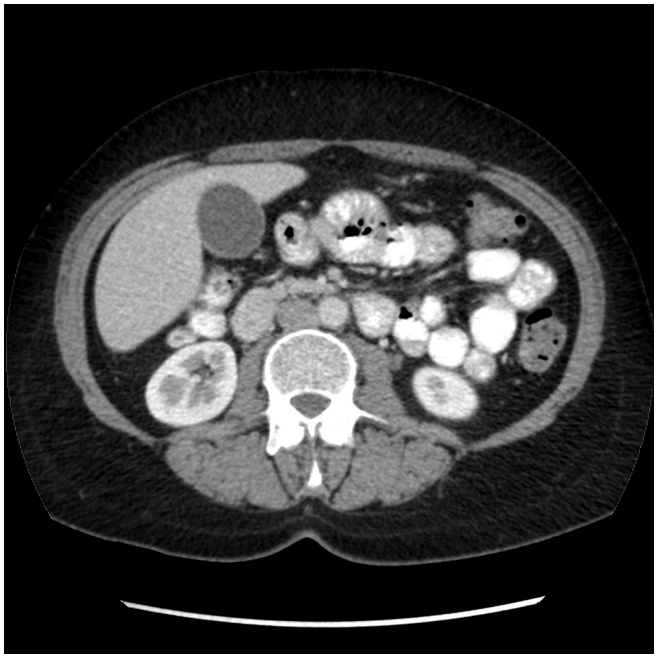

Figure 4. Abdominal CT reconstruction showing normal

The entrance of a Meckel's diverticulum. The bridge between small bowel lumen and entrance is thickened with ulceration (Figure 3), and there iselevated nodular and polypoid lesions have a more reddish mucosa without villi. (Figure 2), ectopic gastric mucosa within the Meckel's diverticulum can be directly visualized as a polypoid mass with reddish mucosa without villi (Figure 1). Pathological results showed active chronic mucosal inflammation with erosion. Gastric biopsy and capsule endoscopy showed there was no obvious ulcer occupying and there was active bleeding in the lower part of small-intestine. Pathological results showed acute and chronic ileac mucosal inflammation, Eosinophils and small sized glandular dysplasia. Initial diagnoses were lower gastrointestinal bleeding, ileum lesionsand treatment was offered including advised regular diet, PPIs and other medications and was admitted for further workout and improvement. After all work out, final diagnosis was perforated meckle's diverticulum and was scheduled for laparoscopic surgery for small bowel disease resection. He underwent surgery and no post-operative complications were complained. The third post-operative day, patient fully recovered and was discharged from hospital with PPIs and other medication. During regular follow ups he had no new complaints and after 6 months of follow-up, patient was very stable with no new complaints.

DISCUSSION

Gastrointestinal bleeding is a major cause of emergency hospital attendance in adults. Nearly 80% of this bleeding in adults originates proximal to the ligament of Treitz. The most common source of the lower gastrointestinal bleeding is colon, with less than 5% of bleeding from small intestine. Meckel's diverticulum is the most common congenital malformation of the gastrointestinal tract most studies suggest an incidence of between 0.6% and 4%. It is also the most common cause of bleeding in the pediatric age group. Our patient was diagnosed with iliac ulcer and managed with PPIs and other drugs with little improvements, since he had a history of blood in stools at the early age (first year) further investigative test was offered and treated without improvements. The results showed that

Ulcers were diagnosed in small intestine Meckle's diverticulum before initiation of the treatment. In our case, we found that alcohol and seafood consumption was the precipitants of the current admitting symptoms, with the fact that alcohol has impact on gastric walls and probably led to corrosion of the iliac walls. There was also a problem of intestinal hemorrhage in the small intestine vasodilation which was repeated after difficulties of other methods. and there was also acute and chronic ileac mucosal inflammation for which surgery was done later. After several surgeries at long last the patient was treated successfully and was discharged from the hospital.

Conclusion

The diagnosis gives a very occasional and interesting case of obscure GI bleeding, the small intestinal bleeding is triggered by drinking alcohol and eating sea food, alcohol can irritate the GI tract and result in GI bleeding or ulcers. The condition should be checked as early as possible to reduce the fatal incidence at adult stages.

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