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Gastroenterology-Endoscopy Quiz - Case 3

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A 76-year-old male patient was admitted in our Gastroenterology Department with 2 episodes of hematochezia and diffuse abdominal pain of acute onset. He also reported chronic fatigue and unexplained transient strokes, and had been diagnosed with hypertension 15 years ago. He had an anamnesis of necrotizing perineal infection (Fournier's disease) 10 years ago, and had undergone cholecystectomy due to cholelithiasis 6 years ago. Due to chronic numbness and paresthesia in his lower extremities he had been evaluated by a vascular surgeon who ordered an abdominal CT scan. Diffuse atheromatosis of all the main abdominal arteries was demonstrated and a sonographic examination of the lower extremity arterial system showed a profound decrease in the blood flow of both posterior tibial arteries. He reported a long-term alcohol abuse and a 60 pack year smoking history. He was under treatment with felodipine-ramipril (Triacor®), propafenone hydrochloride (Rythmonorm®), amiloride (Frumil®), clopidogrel bisulfate (Plavix®), and multivitamin tablets.

Physical examination revealed no palpable pulses in the lower extremities, and the rectal examination was positive for bright red blood. He had tachycardia (100 bpm), blood pressure 100/60 mmHg, but no fever. His lab tests on admission showed: Ht 24.4%, Hb 8.0 g/dL, MCV: 108.20 fL, WBC: 6800 /μL, PLT: 377,000/μL, INR: 1.20, urea: 1.3 mg/dL, creatinine: 1.3 mg/dL, SGOT/AST: 106 IU/L, SGPT/ALT: 26 IU/L, γGT: 20 IU/L, ALP: 10 IU/L, plasma total bilirubin: 0.24 mg/dL, total protein: 6.3 g/dL, albumin: 3.9 g/dL, and serum ferritin 18 ng/mL.

Because the patient was considered to be at high risk of myocardial ischemia due to profound atheromatosis he was transfused with 2 units of packed erythrocytes leading to an increase in his hematocrit level up to 31%. The patient remained hemodynamically stable with remission of hematochezia.

He was then submitted to lower GI endoscopy after bowel preparation with polyethylene glycol (Fortrans™). The colonoscope was inserted into the anal canal until it reached the cecum. From the rectum until the transverse colon there were no specific lesions except for mild edema of the mucosa. In the ascending colon and the cecum several telangiectases (measuring 0.2–0.4 cm in diameter) were observed (fig. 1), one of which bled spontaneously during the endoscopical examination. A similar endoscopical picture was found during the upper GI endoscopy as well. After a more careful physical examination, telangiectases were also present in the mucosa of the oral cavity.

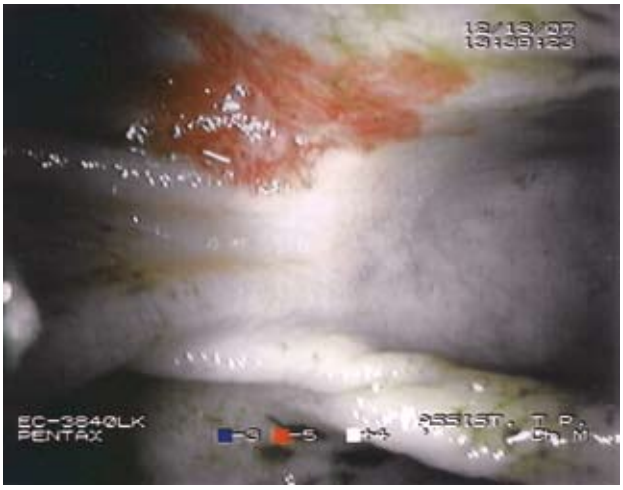

Figure 1.

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Diagnosis: *Hereditary hemorrhagic telangiectasia (Weber-Rendu-Osler syndrome)*