Dieulafoy’s Lesion – An unusual cause of acute abdominal pain in a child
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ABSTRACT
Dieulafoy’s disease is a rare cause of abdominal pain and GI bleeding. A 10 year old girl having recurrent abdominal pain, GI bleeding and epistaxis. Ileal nodularity and prominent submucosal vessels seen in CT angiogram. Child underwent surgical treatment with favorable outcome. Dieulafoy’s disease can cause bleeding at multiple sites due to abnormal dilated vessels.

Keyword: Diuelafoy’s disease, GI bleeding, Dilated vessels.

CASE REPORT

10 year old female child presented to us with history of abdominal pain and vomiting of 2 days duration. Pain is not aggravated by food intake or posture. No history of fever, no history of loose stools/constipation/dysuria/jaundice. Child was given one course of antibiotic in the form of CEFIXIME for 5 days from a local hospital. Child also had multiple episodes of abdominal pain lasting for 2-3 days, last episode occurred 2 weeks back. Before that she had similar episodes which occurred 6 months back and 7 years back. In between she was asymptomatic.

She was born as a TERM baby first born of non-consanguineous marriage/ 3.15 kg birth weight with uneventful perinatal period. Child is fully immunized for age with normal developmental milestones.

No h/o pallor / loss of appetite / weight loss noted by the mother. Mother felt that she was short for her age. No h/o rash / joint swelling. On careful history taking mother gives history of blood stained vomiting at the age of 3 years and 6 months back which was not evaluated at that time.

O/E child was alert. Afebrile, hemodynamically stable. Abdomen was soft, non-tender and with no palpable mass. Child has no organomegaly. Other systems were within normal limits. There were no other external bleeding manifestations.

- Child weight was 29 kg
- Height was 123cm: Stunting present

Child was evaluated by doing CBC, LFT, RFT, coagulation parameters which were within normal limits. Stool Occult blood was positive. Stool for ova, cysts and parasites were negative. Urine R/E & Urine C&S were normal. H.Pylori IgG and IgM were negative. Viral markers for Hepatitis B, C and HIV were negative. Coagulation profile and electrolytes were normal. USG abdomen showed enlarged mesenteric nodes. Upper G.I scope also within normal limits. Colonoscopy showed erythematous areas in colon and ileum with ileal nodularity. Reddish faecal matter seen. CECT abdomen done showed mesenteric lymphadenitis and terminal ileum showed increased mucosal enhancement and few prominent vessels- vascular lesions like Dieulafoy’s lesion. During hospital stay, child has one episode of bleeding per rectum. Child also had minor epistaxis from the left nostril, which subsided by itself. Nasal endoscopy did not reveal any bleeding points.

Child was managed with IV fluids, Pantoprazole, Ondansetron, inj vitamin k and other supportive
measures. Child was seen by surgical gastroenterologist and was treated with laproscopic ligation of the the defective area. Post operative period was uneventful and the child did not have any further episodes of bleeding.

**DISCUSSION**

Dieulafoy’s disease is a rare cause of upper GI hemorrhage and even rarer case of colonic bleeding. Usual presentation is sudden onset of catastrophic bleeding in a previously healthy individual. The diagnosis is often missed because of the small size of lesion.

The disease was first described by Gallard in 1884 and was named by Dieulafoy in 1898. It was defined as an abnormally large artery that retains its large caliber as it reaches the mucosa. Although rare the entity is now being more reported due to increase in the use of endoscopy. The most common location of the lesion is the lesser curvature of the stomach where left gastric artery is involved.

The exact cause of the lesion whether genetic or acquired is not known. The condition can occur at all ages and is more common in males than in females. Depending on the site of involvement, the patient can have hematemesis, melena, hematochezia or hemoptysis. The lesion usually causes symptoms when the overlying lining wears off exposing the artery. The DIEULAFOY’S lesion are small in size making them hard to see on endoscopy. Diagnostic methods include endoscopy and CT angiography.

The important differential diagnosis includes angiodysplasia characterized by vascular ectasia and AV shunting whereas Dieulafoy’s disease is characterized by mucosal erosion overlying a large dilated submucosal artery. Other important differential diagnosis includes vascular neoplasms, telengectasia which can be associated with Osler Weber Rendu syndrome, Turner syndrome and systemic sclerosis.

These conditions can be distinguished based on their endoscopic and angiographic findings. Treatment includes endoscopic resection, application of bands or clips or embolization of abnormal vessels.

In our case the child initially has recurrent episodes of abdominal pain with two episodes of blood stained vomiting. Subsequently the child had rectal bleeding and epistaxis. The diagnosis was confirmed by the findings observed on colonoscopy and CT angiography. Since the child had bleeding manifestation in the form of epistaxis also, there is a possibility of abnormal, dilated arterial walls in these areas also.

We conclude that Dieulafoy’s disease although rare should be considered as differential diagnosis in children presenting with abdominal pain and blood stained vomiting.

**Contributors:**
SK, FV, SS, LK: case management and critical review of manuscript; SK, FV, HH: data collection and manuscript preparation

**REFERENCES**


