

gastric cancers in the form of higher incidence of vascular invasion, lymph node and liver metastasis.¹³

Data regarding optimum therapy of AFPGC is sparse. The treatment is similar to that of common gastric adenocarcinoma. Surgical management of an early primary tumor, if feasible, is the indicated approach. Adjuvant chemotherapy and radiotherapy should be given according to current gastric cancer indications, despite the fact that no specific data on adjuvant treatment of AFPGC is available.

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Dieulafoy's disease of jejunum resulting in massive haemorrhage

Dieulafoy's lesion is a rare vascular anomaly which can cause life threatening haemorrhage. This lesion is usually seen in stomach and only rarely located in small intestine.

Case Report

A young female aged 21 years was admitted to our hospital in haemorrhagic shock. There was history of

four episodes of frank bleeding per rectum for two days. Physical examination revealed pallor, un-recordable blood pressure and on per abdominal examination no organomegaly. Her hemoglobin was 3.7 gm/dl, platelet count was 86,000 per cu mm. Dengue serology, both IgM and IgG were negative. She was managed with multiple blood transfusions consisting of 3 units of packed red blood cells (PRBCs) and 5 units of fresh frozen plasma (FFP). Upper Gastrointestinal (GI) endoscopy revealed no abnormality and colonoscopy showed stools with melena. In view of her condition, a decision for intra operative endoscopy of the small intestine, for localization of the bleed, was taken. Intraoperative endoscopy revealed a small approximately 1 cm elevation in proximal jejunum (about 10-15 cm from the duodeno-jejunal junction) with an active spurt of bleed (**Figure 1-a**). A small segment (4 cm) of jejunum was resected. Post operatively the patient improved, but required further hemodynamic support with transfusions. A total of 9 units of PRBCs and 7 units of FFP were given to the patient. Subsequently, she was discharged in a stable condition.

The resected specimen of jejunum on gross examination revealed 0.5-1 cm small elevated area in the mucosa with an appearance suggesting presence of large vessel with blood in lumen under it. Microscopic examination revealed a large ectatic vessel of diameter 6 mm in the submucosa with fibrinous exudate entangling neutrophils on the surface. Vessel wall showed mild myxoid change in media (**Figure 1-b**). Vessel wall did not reveal any elastic tissue. The lesion was diagnosed as Dieulafoy's lesion.

Discussion

Originally described by Gallard in 1884 as military aneurysm of stomach and subsequently by Paul Georges Dieulafoy in 1987 as a lesion causing massive haemorrhage in the stomach, these lesions are now reported throughout the GI tract (stomach 71%, esophagus 8%, duodenum 15%, jejunum and ileum 1%, colon 2%, rectum 2% and rarely in anal canal).¹ Few cases involving bronchus have also been reported.² In stomach, lesser curvature within 6 cm of the gastro-esophageal junction is the common site. Dieulafoy's lesion is a large arterial vessel in submucosa, the

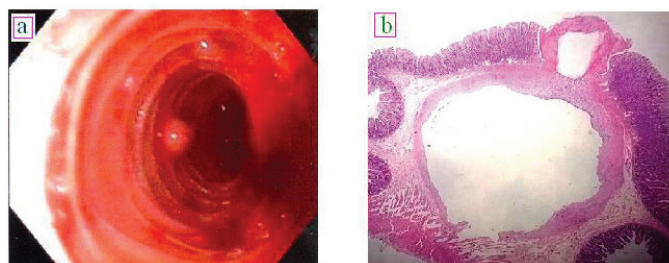


Figure 1: (a) Preoperative enteroscopy 1 cm raised lesion in jejunum. (b) Submucosal blood vessel with mucosal defect (H and E, x 40).

diameter of which is abnormal for this site and potentially lead to massive GI haemorrhage. Factors contributing to bleed can be pulsation of the large submucosal vessel, gastric wear and tear promoting thrombosis leading to necrosis of overlying mucosa, NSAIDs, alcohol and age related changes.^{1,3} These factors cause mucosal erosion and ischemic injury to the vulnerable point and unmask the silent anomaly. The abnormal vessel was initially considered as aneurysmal, but now is known to be neither an aneurysm nor affected by atherosclerosis or arteritis.³ The possibility of its being a congenital anomaly is considered in view of reports of neonates being affected.³ On angiogram, extravasation of contrast into GI system from an eroded artery is indicative of such a lesion, as is presence of a tortuous ectatic vessel in arterial phase without early venous return which distinguishes it from arterio-venous-malformation. Angiography identifies the lesions that can be successfully embolized.⁴

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