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Clinical Image

Rectal Dieulafoy's Lesion Detected Using MRI of Pelvis – First of it's Kind

Kiran S*, Abhinav Jain, Deepak Gupta and Akash Shukla
Department of Gastroenterology, Seth GS Medical College and KEM Hospital, Mumbai, India

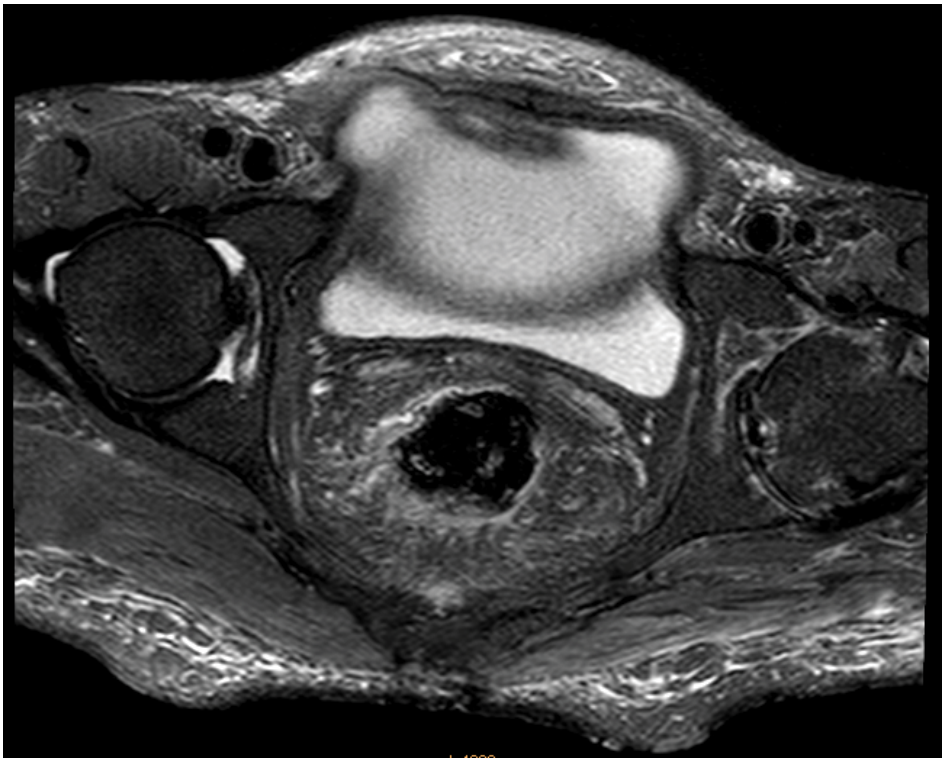

Figure 1: Persistent caliber arteriole seen in rectal sub-mucosa with breach in overlying mucosa.

A 34-year-old man was admitted with a history of intermittent painless hematochezia for 4 months. He was transfused 6 units of packed red blood cells over the past 2 months elsewhere, due to significant blood loss. On general examination, he had pallor and tachycardia. Abdominal examination was unremarkable. He underwent flexible-sigmoidoscopy in an unprepared colon, immediately on admission since he was actively bleeding per rectum. Fresh blood was seen in the anal canal and lower rectum with normal colonic mucosa beyond but no bleeding source was identified. When the bleeding spontaneously resolved, colonoscopy was repeated in a prepared colon, but to no avail. Contrast enhanced MRI (CEMRI) of the pelvis and abdomen was done, which showed a suspicious persistent caliber arteriole coursing through the sub-mucosa into the rectum, with a defect in the overlying mucosa (Figure 1). A repeat flexible-sigmoidoscopy was performed during the next episode of bleeding, at which time careful irrigation showed a spurting site approximately 8 cm from anal verge. This was injected with 3 ml of 1.5% sodium tetradecyl sulfate, with blanching of the mucosa and subsequent cessation of bleeding. The patient was followed for a year without recurrence of complaints.

Dieulafoy's lesion was originally reported by Gallard and described in detail by Dieulafoy [1], a French surgeon in the year 1889. Histologically, the lesion is defined as a thick -walled arterial vessel surrounded by a shallow ulcer [2]. Originally thought to be confined to the stomach, Dieulafoy's lesions have since been rarely reported in the esophagus [3], small bowel and colon [4,5]. The diagnosis of Dieulafoy's lesion of the large bowel may be difficult because poor bowel preparation and stagnant blood contribute to poor visualization. Mesenteric angiography may miss bleeding arising from the lower rectum, as its blood supply does not arise from the mesenteric artery; thus internal iliac arterial angiogram is also necessary to detect bleeding from the

***Corresponding author:** Kiran S, Department of Gastroenterology, Seth GS Medical College and KEM Hospital, Mumbai, India; Tel: 022-2410-7034; Email: drvjkirans@yahoo.co.in*

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inferior rectal artery in the case of an anorectal Dieulofoy's lesion [6]. This is the first reported case of a rectal Dieulafoy's lesion which was detected on CEMRI of the pelvis and later identified and treated successfully endoscopically.

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