

EDITOR'S QUIZ: GI SNAPSHOT

Obscure GI bleeding in a young man

CLINICAL PRESENTATION

A 27-year-old healthy man presented with a 3-week history of melena along with iron-deficiency anaemia (haemoglobin: 60 g/L). Upper endoscopy and colonoscopy were performed and were normal. The patient was referred for enteroscopy after capsule endoscopy revealed the presence of blood in the proximal jejunum without visualisation of an underlying lesion.

On further questioning, patient denies having any GI or extraintestinal symptoms prior to onset of melena. He denied having weight changes and had no recent history of non-steroidal anti-inflammatory drugs use.

Push enteroscopy was performed using a PENTAX paediatric colonoscope. At 90 cm beyond the pylorus, note was made of a

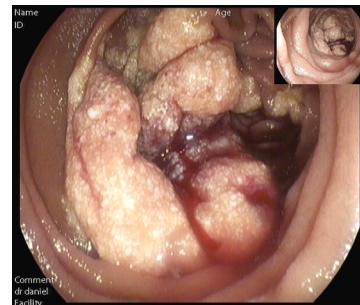


Figure 1 Semicircumferential lobulated mass in the proximal jejunum harbouring multiple whitish nodularities with blood oozing.

semicircumferential mass occupying three to four jejunal folds, harbouring multiple whitish nodularities (figure 1). Mild blood oozing was present.

QUESTION

What is your presumed diagnosis?

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ANSWER

Histopathological examination of biopsy specimens obtained from the mass revealed dilated mucosal lacteals suggestive of a lymphangiomatous lesion. The patient underwent a subsequent laparoscopic segmental jejunal resection. Gross examination findings are described in figure 2A,B.

Findings on histopathology were diagnostic of jejunal lymphangiectasia (figure 3A,B).

Intestinal lymphangiectasia is virtually always an incidental finding without clinical consequences, identified in the duodenum in 1.9% of adults undergoing routine upper endoscopy and is commonly identified on capsule endoscopy.¹ Typical features include scattered white plaques and submucosal elevations.² On the rare occasions when the disease is symptomatic, findings tend to be much more extensive, and patients commonly present with symptoms of protein-losing enteropathy.³ In that case, the disease can be idiopathic (primary lymphangiectasia), however, ensuring that it is not secondary to other causes is of extreme importance (downstream intestinal obstruction, circulatory problems, infectious and inflammatory processes, or malignant lymphoma).⁴

A less common presentation is occult GI bleeding likely as a result of intestinal ulcerations.⁴ It is quite uncommon for the disease to result in overt GI bleeding such as in our patient. Our case is unique as it offers an atypical location and presentation of a primary localised intestinal lymphangiectasia.

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Contributors FD, RA and RR identified and managed the case. FD planned and supervised the workflow. FD was also the guarantor of the study. RA performed the literature review, wrote the manuscript and adjusted images quality to meet the journal requirements. RR provided pictures of surgical pathology specimen as well as histopathology slides (along with their descriptions).

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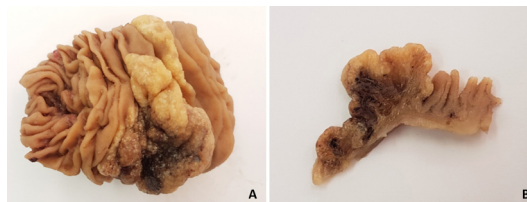


Figure 2 (A) Surgical specimen. Note the edematous aspect of the jejunal mucosa with whitish swollen villi as well as haemorrhagic villi. (B) Full-thickness section showing cystically dilated spaces in the mucosa and submucosa on the left compared with the normal appearance of the jejunal wall on the right.

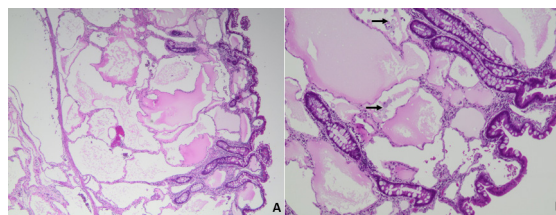


Figure 3 (A) Low power view of dilated lymphatics involving intestinal mucosa and submucosa (H&E; 40x). (B) High power view showing intestinal mucosal involvement with dilated lymphatics. The latter contain foamy macrophages (arrows) and lymphatic protein. Surface epithelial cells are normal (H&E; 400x).

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