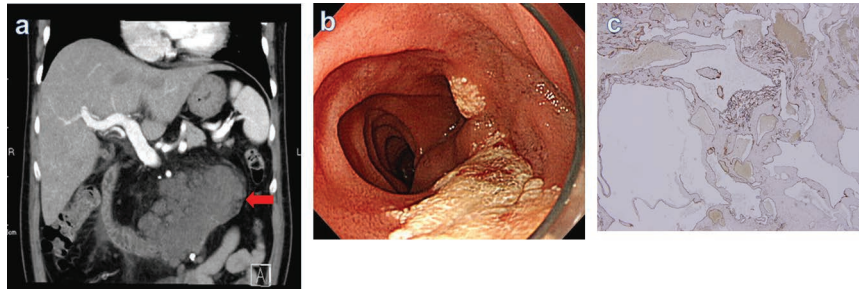


Small Intestinal Lymphangioma With Lymphangioectasia Causing Obscure Gastrointestinal Bleeding

Mao-Yu Huang^{1,2}, Hao-Ming Chang³, Hong-Wei Gao⁴ and Tien-Yu Huang^{2,5}

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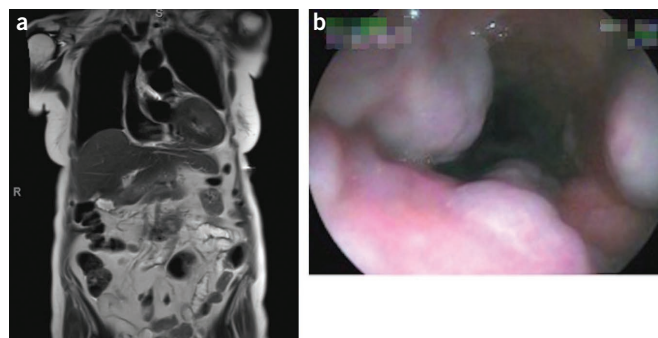
A 58-year-old man presented with a 2-week history of progressive exertional dyspnea and dizziness. He had also experienced episodic melena for 3 days. A complete blood count revealed severe anemia (hemoglobin: 3.5 g/dl). Computed tomography showed a lobulated mass (about 15 cm) surrounding the third portion of the duodenum (a). The results of esophagogastroduodenoscopy and colonoscopy were negative. Single-balloon enteroscopy revealed several whitish plaques with bloody oozing and extraluminal compression located at the third portion of the duodenum (b). Biopsy specimens were obtained and hemoclippping was performed. The pathology was compatible with lymphangiectasia. This patient underwent exploratory laparotomy with tumor resection. The surgical specimen was a soft, yellow-pink lesion 15 × 15 cm in size. Histopathology revealed clusters of variable-sized dilated lymphatic channels, consistent with a small-bowel lymphangioma (c). The patient's melena and symptoms related to anemia resolved after surgery. (Informed consent was obtained from the patient to publish these images.)

¹Division of Gastroenterology, Department of Internal Medicine, Taoyuan Armed Forces General Hospital, Taoyuan County, Taiwan; ²Division of Gastroenterology, Department of Internal Medicine, Tri-Service General Hospital, National Defense Medical Center, Taipei, Taiwan; ³Division of General Surgery, Department of Surgery, Tri-Service General Hospital, National Defense Medical Center, Taipei, Taiwan; ⁴Pathology Department, Tri-Service General Hospital, National Defense Medical Center, Taipei, Taiwan; ⁵Taiwan Association for the Study of Small Intestinal Diseases, Taoyuan City, Taiwan.

A Rare Case of Downhill Esophageal Varices in the Absence of Superior Vena Cava Obstruction

Samirallah Gholam¹, Sehem Ghazala², Bhupesh Pokhrel³ and Archita P. Desai^{3,4}

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An 87-year-old woman was admitted for dyspnea. Physical examination revealed tachycardia and bilateral pulmonary crackles. Her hemoglobin level was 5.6 g/dl on admission, and iron studies were consistent with iron-deficiency anemia. Platelet and electrolyte levels and prothrombin time were normal. Her alanine aminotransferase and aspartate aminotransferase levels were 109 IU/l and 60 IU/l, respectively. Her brain natriuretic peptide was elevated. The results of a hepatitis panel were negative. A 2-D echocardiogram showed severe aortic stenosis and markedly elevated right ventricle systolic pressure. Magnetic resonance imaging (MRI) of the chest and abdomen was significant for discrete midesophageal varices with no imaging findings of advanced chronic liver disease or changes indicating portal hypertension. MRI of the chest was absent for superior vena cava (SVC) obstruction (a). The findings of an esophagogastroduodenoscopy were significant for three columns of large varices in the upper third of the esophagus with no stigmata of recent bleeding and the presence of Cameron lesions (b). The severe anemia was therefore attributed to Cameron ulcers. This case demonstrated the presence of “downhill” varices in the setting of pulmonary hypertension caused by aortic stenosis in the absence of SVC obstruction and liver cirrhosis. (Informed consent was obtained from the patient to publish these images.)

¹Department of Internal Medicine, Kern Medical Center, Bakersfield, California, USA; ²Department of Internal Medicine, University of Arizona, Tucson, Arizona, USA; ³Division of Gastroenterology and Hepatology, Department of Medicine, University of Arizona, Tucson, Arizona, USA; ⁴Division of Gastroenterology, Liver Research Institute, University of Arizona, Tucson, Arizona, USA.