中文題目：致命出血的隱藏殺手: 直腸 Dieulafoy's lesion 的病例報告

英文題目：A stealth killer causing life-threatening bleeding. A case of rectal Dieulafoy's lesion.

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Introduction: Dieulafoy's lesion is an unusual, but potentially life-threatening cause of acute gastrointestinal bleeding. The lesion is characterized by a dilated tortuous submucosal artery that erodes overlying gastrointestinal mucosa. The lesion can be present throughout the gastrointestinal tract, but most located in the stomach, usually within 6 cm of the gastro-esophageal junction. We report a case of acute lower gastrointestinal bleeding due to rectal Dieulafoy' s lesion.

Case presentation: A 79-year-old woman presented to our emergency department due to bloody stool for 3 days. She had the medical history of hypertension, type 2 diabetes mellitus, previous cerebrovascular accident under clopidogrel use and end-stage renal disease under hemodialysis. At emergency department, her vital signs were blood pressure of 142/77 mmHg, heart rate of 81 beats per minute and her temperature of 36.7^{o} C. Notable laboratory findings included a hemoglobin 10.0 g/dL and a white blood cell count of 10.56 x10^3/ul. Due to her massive bloody stool, upper gastrointestinal endoscopy and colonoscopy were done, yet showing negative finding. Computed tomography angiography showed no active bleeding. However, recurrent bleeding noted 2 weeks later, and repeated colonoscopy still showed negative finding. Two hours post-colonoscopy, massive bloody stool with shock was noted. Emergent angiography demonstrated engorged vessels at right lateral wall of rectum with contrast medium extravasation (Figure 1). A repeat sigmoidoscopy revealed rectal ulcer with visible vessel bleeding (Figure 2). Hemostasis was achieved with 3 hemostatic clips (Figure 3). Her bloody stool eventually stopped, and she was discharged after 1 month of hospital stay.

Discussion: Endoscopy is the first choice for Dieulafoy' s lesion, not only as a diagnostic tool but also as a therapeutic intervention. However, multiple endoscopies are often necessary for lesions easily overlooked or misidentified at endoscopy. The lesion may be covered with clot or be obscured by active bleeding. However, it may also be easily missed when the lesion is not actively bleeding due to no mucosal ulceration surrounded. Angiography as well as computed tomography angiography can be helpful and effective when endoscopy fails to localize the lesion. It is especially useful with the view obscured by active bleeding and poor bowel preparation.

Conclusion: Dieulafoy' s lesions are a rare cause of gastrointestinal bleeding which may result in life-threatening condition. Dieulafoy' s lesions should be included in

the differential diagnosis of obscure gastrointestinal bleeding. Once identified, they can be successfully treated with endoscopic hemostatic procedures including epinephrine injection, sclerotherapy, band ligation, thermal cautery, or hemostatic clips.