

## Letters to the Editor

### Duodenal hematoma caused by endoscopic hemostatic procedures (sclerotherapy)

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*Key words:* Intramural duodenal hematoma. Sclerotherapy.

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*Dear Editor,*

We report the case of a 24 year old male without any relevant past medical history who was admitted to the hospital with acute upper gastrointestinal bleeding (melena). The upper gastrointestinal endoscopy showed a peptic ulcer in the anterior wall of the bulb with a spurting hemorrhage; 10 cc of dilute (1/10,000) epinephrine and 8 cc of ethanolamine was injected into the areas adjacent to the ulcer.

After two weeks, the patient returned to hospital due to colic epigastric pain with elevated lipase and amylase levels in the blood tests. Computerized tomography (CT) identified a hypoechoic, homogenous mass in the pancreatic head (Fig. 1). The endoscopic ultrasound showed an increased concentric duodenal wall thickness that was consistent with a duodenal hematoma. The patient was referred to the hematology clinic and diagnosed with idiopathic thrombocytopenic purpura.

#### Discussion

Duodenal intramural hematoma is an unusual condition. Blunt abdominal trauma is usually the cause in most cases (1). Non-traumatic hematomas usually result from anticoagulant

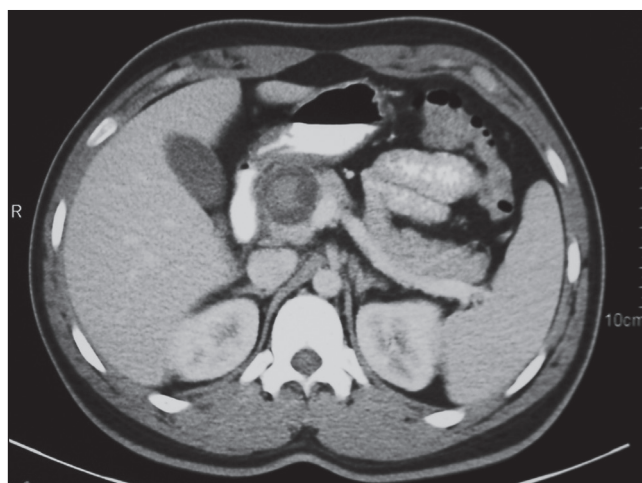


Fig. 1. Homogenous mass in the pancreatic head.

treatment, blood dyscrasia, pancreatic diseases and diagnostic or therapeutic endoscopic procedures (biopsy, sclerotherapy or APC) (2).

They usually occur on the posterior wall of the duodenum and patients present with symptoms of abdominal pain, vomiting and rarely hematochezia. Abdominal CT is an excellent tool for diagnosis (3).

Conservative treatment usually leads to the improvement of symptoms within 1-3 weeks. When conservative treatment is not effective, surgical drainage and ultrasound or CT-guided drainage are used (4). In cases involving complete intestinal obstruction or pressure on adjacent organs, the hematoma should be identified as early as possible and evacuated dynamically in order to avoid a fatal outcome (acute pancreatitis, obstructive jaundice, aspiration pneumonia and septic shock) (5).

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## References

1. Jones WR, Hardin WJ, Davis JT, et al. Intramural hematoma of the duodenum : a review of the literature and case report. *Annals of Surgery* 1971;4:534-44.
2. Grasshof C, Wolf A, Neuwirth F, et al. Intramural duodenal haematoma after endoscopic biopsy: case report and review of the literature. *Case Reports in Gastroenterology* 2012;1:5-14. DOI: 10.1159/000336022
3. Chang CM, Huang HH, How CK. Acute pancreatitis with an intramural duodenal hematoma. *Internal Medicine* 2015;7:755-7. DOI: 10.2169/internalmedicine.54.3147
4. Nolan GJ, Bendinelli C, Gani J. Laparoscopic drainage of an intramural duodenal haematoma; a novel technique and review of the literature. *World Journal of Emergency Surgery* 2011;6(1):42. DOI: 10.1186/1749-7922-6-42
5. Calhan T, Sahin A, Kahraman R, et al. A lethal complication of endoscopic therapy: duodenal intramural Hematoma. *Case Rep Gastrointest Med* 2015;2015:201675. DOI: 10.1155/2015/201675