

Contemporary limitations when encounter with Dieulafoy's Lesion (DL).

Asa Yua*

Department of Pediatric Surgery, Kyushu University, Nishi-ku, Fukuoka, Japan

Abstract

Dieulafoy's lesion has been linked to 177 incidences of upper gastrointestinal bleeding. Severe and recurring upper gastrointestinal haemorrhage is frequently caused by Dieulafoy's lesion. The majority of the lesion was identified in the proximal stomach. In 33 percent of the patients, further endoscopies were required to confirm the diagnosis. Surgery was an effective therapeutic approach when preoperative diagnosis and localisation were done. In 85% of reported instances, therapeutic endoscopy was successful in obtaining permanent hemostasis. Re-treatment was required in 10% of the instances, and surgical therapy was required in 5% of the cases. In all cases, therapeutic endoscopy should be considered first. If endoscopic therapy fails, surgical surgery and angiography with embolization may be viable choices.

Introduction

Dieulafoy's lesion is generally asymptomatic (asymptomatic). When symptoms are present, they usually involve painless bleeding, blood vomiting (hematemesis), and/or dark faeces (melena). Dieulafoy's lesions are less likely to produce rectal bleeding (hematochezia) or iron deficiency anaemia. There are usually no gastrointestinal symptoms prior to the bleeding (abdominal pain, nausea [1].

Dieulafoy lesions in the gallbladder, albeit extremely rare, can produce upper abdomen pain, commonly in the right upper quadrant or upper middle (epigastric). Although gallbladder Dieulafoy lesions are frequently associated with anaemia (83%), they rarely cause visible bleeding (hematochezia, hematemesis, melena, etc [2].

Pathophysiology

In the absence of any ulcer, erosion, or other abnormalities in the mucosa, Dieulafoy lesions are defined by a single excessively big blood artery (arteriole) beneath the gastrointestinal mucosa (submucosa) that bleeds. These blood arteries range in size from 1 to 5 mm (more than 10 times the normal diameter of mucosal capillaries). Pulsation from the larger vessels generates focal pressure, which promotes thinning of the mucosa in that area, exposing the vessel and causing haemorrhage [3].

Dieulafoy's lesions are most common in the lesser curvature of the stomach, around 75% of which occur within 6 cm of the gastroesophageal junction. Dieulafoy's lesions, on the other hand, might appear anywhere in the gastrointestinal tract. Extragastic lesions had been regarded to be infrequent in the past. However, due to improved knowledge of the illness, they have been found more frequently in recent years. The duodenum (14%) is the most prevalent site, followed

by the colon (5%), surgical anastomoses (5%), the jejunum (1%), and the oesophagus (1%). The gallbladder has been reported to have Dieulafoy's lesions. The pathogenesis of these extragastric lesions is nearly identical to that of the more common gastric lesion.

Diagnosis

The intermittent pattern of bleeding makes a Dieulafoy's lesion difficult to diagnose. Dieulafoy's lesion is usually discovered through an endoscopic examination, usually an upper endoscopy, which reveals a single protruding blood artery. During a colonoscopy, lesions affecting the colon or the end of the small bowel (terminal ileum) can be detected. Dieulafoy's lesions are difficult to recognise, hence numerous endoscopic exams may be required. The mucosa near a Dieulafoy's lesion can be injected with ink once it has been discovered via endoscopy. In the case of rebleeding, tattooing the area can help pinpoint the site of the Dieulafoy's lesion. Endoscopic ultrasound has been utilised to aid in the diagnosis of Dieulafoy lesions as well as to confirm treatment success [4,5].

Angiography can aid in diagnosis, however it only detects bleeding that happens while the test is being performed. Mesenteric angiography may be especially useful for Dieulafoy lesions in the colon or rectum, where the presence of blood or inadequate bowel preparation may limit the examination.

Treatment

Dieulafoy lesions are usually treated with endoscopic procedures. Epinephrine injection followed by bipolar or monopolar electrocoagulation, injection sclerotherapy, heater probe, laser photocoagulation, hemoclipping or banding is some of the endoscopic procedures employed in the treatment. Interventional radiology may be contacted in cases of

*Correspondence to: Asa Yua. Department of Pediatric Surgery, Kyushu University, Nishi-ku, Fukuoka, Japan, E-mail: Yua55@okayama.ac.jp

Received: 02-May-2022, Manuscript No. JGDD-22-65754; Editor assigned: 04-May-2022, PreQC No. JGDD-22-65754 (PQ); Reviewed: 18-May-2022, QC No. JGDD-22-65754;

Revised: 21-May-2022, Manuscript No. JGDD-22-65754 (R); Published: 25-May-2022, DOI:10.35841/jgdd-7.5.122

refractory bleeding for an angiography with subselective embolization [6].

References

1. Lee YT, Walmsley RS, Leong RW, et al. Dieulafoy's lesion. *Gastrointestinal Endoscopy*. 2003;58(2):236-43.
2. Baxter M, Aly EH. Dieulafoy's lesion: Current trends in diagnosis and management. *Ann R Coll Surg Engl*. 2010;92(7):548-54.
3. Romaozinho JM, Pontes JM, Lérias C, et al. Dieulafoy's lesion: Management and long-term outcome. *Endoscopy*. 2004;36(05):416-20.
4. Mikuta JJ. International Federation of Gynecology and Obstetrics staging of endometrial cancer 1988. *Cancer*. 1993 Feb 15;71(S4):1460-3.
5. Norton ID, Petersen BT, Sorbi D, et al. Management and long-term prognosis of Dieulafoy lesion. *J Gastrointest Endosc*. 1999;50(6):762-7.
6. Yoshida T, Adachi K, Tanioka Y, et al. Dieulafoy's lesion of the esophagus correctly diagnosed and successfully treated by the endoscopic injection of N-butyl-2-cyanoacrylate. *Endoscopy*. 2004;36(02):183-5.