Editorial

Emerging Rare Causes of Lower Gastrointestinal Bleeding

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Lower gastrointestinal bleeding (LGIB) is defined as bleeding from a source located at any point in the lumen of the small bowel from ligament of Treitz and the large bowel down to the anal opening. The ligament of Treitz has been considered to be the fibrous band of tissues that plastered the duodenojejunal junction to the posterior peritoneum. It is often referred as the reference point of LGIB. As it is a well-known fact, LGIB has been a significant cause of morbidity and mortality worldwide.[1] There are numerous causes which are often classified as common causes because they occur quite common in virtually every community and rare causes which rarely occur or cause a threat to life. However, in the recent times, these so-called rare causes are becoming significant causes, particularly in the presence of certain conditions[2] couple with new causes that were not known before. These, together constitute an emerging rare cause of LGIB which this editorial intends to highlight.

DIEULAFOY'S LESION

Dieulafoy's lesion, named after the French surgeon, Dr. Paul Georges Dieulafoy that first reported it in 1898,[3] is a large superficial, tortuous artery underlying a mucosal defect which is rare and difficult to find, especially when it is not bleeding. This lesion has been a rare cause of LGIB in the past and found only in 5% of adults.[1,2] However, it is becoming a significant cause of LGIB. In the past, approximately 75% of cases are said to occur in the upper part of the stomach. Extragastric lesions in the duodenum, anastomotic site, small and large bowel were extremely rare but have been identified more frequently in recent years likely due to increased awareness and advancement in diagnostic imaging such as endoscopic ultrasound and angiography.

COMORBIDITY DISEASES

Comorbidity has been found to increase the incidence of LGIB.[2] Some of the comorbid diseases that have been incriminated include cardiovascular diseases, renal disease, hypertension, and diabetes mellitus. There are varied ways, in which the presence of comorbid diseases is thought to cause LGIB. For instance, diseases such as atherosclerotic cardiovascular disease that has affected the splanchnic circulation is a significant cause of ischemic bowel disease.[4] Severe ischemia from this condition leads to tissue necrosis which is subsequently followed by sloughing and bleeding in the GI tract.

POLYPHARMACY

The use of multiple drugs/medications is another rare cause of LGIB. Anticoagulants and nonsteroidal anti-inflammatory drugs are known causes of gastric or upper GI bleeding. However, in the recent times, they have also been found to have caused ulceration of both the small as well as large bowel. This ulceration coupled with their known inhibitory effect on blood clotting factors may lead to significant LGIB. Notably, the use of multiple drugs by people in the society is gradually increasing with an alarming rate both as a result of increased rate of drug abuse and an increased use of multiple drugs by elderly people. An increased population of elderly people has been identified as an attributable factor to increase the use of multiple drugs. The presence of comorbidity in the elderly together with attendance use of multiple drugs is double tragedy to increasing incidence of LGIB. Therefore, polypharmacy needs to be ruled out particularly when an elderly patient presents with LGIB.

IRRADIATION

Advancement in technology has paved way to various modalities in the management of malignant conditions. Apart from surgery, chemotherapy, hormonal manipulation, irradiation is gradually becoming a common option of management of malignant conditions. This is because it is becoming available and accessible to patients and their care providers, the oncologists. Therefore, with a rising trend of malignant conditions and an increased use of irradiation, LGIB due to irradiation is gradually becoming common and significant in recent times.

STERCORAL ULCERS

Stercoral ulcers are considered to be those ulcers that result from mucosal damage due to hard imparted stools in the rectum, foreign body, or manipulation injury.

The rising trend of lower endoscopy and minimal access surgeries[5] may be attributable to the rising trend of this rare cause of LGIB. Recently, cases of massive LGIB from stercoral ulcers have been reported.[4]

LIVER CIRRHOSIS

Liver cirrhosis is another emerging cause of LGIB. Even though it is not completely new, a rising trend of cases calls for concern and a high index of suspicion.[2,6] At this point, I wish to share my experience with a case of LGIB in a patient with liver cirrhosis in whom there was a diagnostic dilemma. Clinically, the patient's main features were those of recurrent LGIB of 2 months duration associated with progressive weight loss, body weakness, and poor appetite. The patient did not have history of petechial hemorrhage, no history of bleeding from mouth, nose, or other body orifices. Examination revealed pallor and cachexia otherwise normal clinical findings. The patient had no stigmata of chronic liver disease. Report of abdominal ultrasound was essentially normal findings. Abdominal computed tomography (CT) scan including CT colonoscopy were normal. Electrolytes were normal. The clotting profile was not done because there was no clue or clinical indication. The patient was resuscitated and explored. Amazingly, the intraoperative finding was widespread micro nodules on all the lobes of the liver. A biopsy was taken, in which histology result confirmed a cirrhotic liver. He was managed subsequently with only palliative measures including repeated blood transfusions (had 4 units of blood) before his demise.

CONCLUSION

There is an emerging trend of rare causes of LGIB. Some of them posing great diagnostic dilemma. Therefore, there is need for a high index of suspicion. Adequate resuscitation and prompt treatment are keys to a successful management of such patients.

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