■ S-75 ■

Bleeding by 2 synchronous Dieulafoy's lesions: successful endoscopic management

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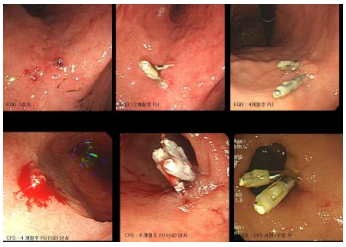
Dieulafoy lesions are an uncommon cause of gastrointestinal bleeding. We report the first case of bleeding by 2 synchronous dieulafoy lesions at which were successfully treated by endoscopic management. A 46-year-old male presented with 10 episodes of melena and 5 episodes of hematemesis over 12 hours duration. An urgent upper gastrointestinal endoscopy revealed moderate amount of blood in the stomach and 0.3 ~ 0.5cm mucosal defect with a protruding vessel on the lesser curvature of angle, suggested Dieulafoy lesion. Endoscopic hemoclips were applied to secure hemostasis. After two month later, repeat endoscopy showed normal mucosa in the involved area with still hemoclips. But, four month after his discharge, he presented with 5 episodes of hematochezia over 6 hours duration. An upper gastrointestinal endoscopy showed intact mucosa in the same area with hemoclips too, without any bleeding focus. And then, colonoscopy without bowel preparation was performed to reveal moderate amount of blood in whole colon and distal terminal ileum. At the distal terminal ileum, 15cm apart from ICV, micropulsatile streaming of blood from a 0.3cm mucosal defect surrounding normal mucosa suggested a Dieulafoy lesion. Hemoclips were applied at the lesion with injection of 2 mL of 1:10,000 solution of epinephrine to secure hemostasis. Repeat colonoscopy performed 1week later, showed normal mucosa in the involved area with still hemoclips without any complication.



■ S-76 ■

Gallstone ileus without a gallbladder

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Gallstone ileus is an unusual disease, which accounts for 1~4% of all cases of intestinal obstructions. Furthermore, there are few case reports of gallstone ileus in the absence of gallbladder, because it is usually the result of fistula formation between the gallbladder and intestine facilitating entry of the stone into gastrointestinal tract. As it primarily affects the elderly, gallstone ileus is still associated with high rates of morbidity and mortality. It is often missed or diagnosed late. The presentation is that of intestinal obstruction preceded by biliary complaints. Radiological findings include features of intestinal obstruction and pneumobilia, and an aberrant gallstone. Contrast enhanced abdominal CT is an important diagnostic aid. Treatment depends on the site of the impacted stone, but surgery is needed in many cases. We describe a rare case of a 92-year-old man who presented with a short history of abdominal pain and vomiting. He has undergone open cholecystectomy with T-tube choledocholithotripsy five years ago due to gallstones and common bile duct stones and, again, an ERCP stone removal with endoscopic sphincterotomy due to recurrent CBD stones four years ago. On evaluations he was found to have small bowel obstruction caused by wedging of a large gallstone at the jejunum. As abdominal symptoms and signs were getting worse and considering his old age, open enterolithotomy was undertaken relieving the obstruction and the patient made a full recovery to discharge 10 days later.