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Case Report

In Digestive Endoscopy Not Everything Is Always at First Sight

Greco S[1], Burti C[1], Grieco L[1], Occhipinti V[1] and Marra P[2]*

[1]*Department of Medicine, Gastrointestinal Unit II, Bergamo, Italy*

[2]*Department of Radiology, Interventional Radiology, Bergamo, Italy*

Abstract

We illustrate a case of gastric bleeding secondary to a lesion that is not easily visible and where endoscopic ultrasound reveals the vascular anomaly.

With this case report we would demonstrate that an integrated approach allows the detection of this unusual lesion and its prompt and effective management.

Keywords: Dieulafoy's lesion; Endosonography

Case Presentation

A 44-year-old male without comorbidities or medications intake, presented with hypotension, tachycardia, and important hematemesis. Blood tests were consistent just with acute anemia.

The only suspicious finding at Esophagogastroduodenoscopy (EGDS) was a subcardial mucosal area slightly raised and oedematous, finding that could have been interpreted as "inflammatory" but above all lacked a correlation with bleeding. However, we decided to evaluate this finding with upper endosonography examination, revealing an abnormally large caliber submucosal artery in the same region (Figure 1a).

After a new episode of hematemesis, a second EGDS revealed a few-millimeter pulsatile lesion that emerged the mucosa with oozing (Figure 1b). Haemostasis with epinephrine and hemoclips was performed, but bleeding was not controlled.

Urgent angio-CT scan (Figure 1c) showed the absence of the splenic artery. The subsequent angiography found an increased caliber of the left gastric artery with abnormal fundal branches feeding the spleen. A pathologic vascular tangle was evident (Figure 2a). Super selective embolization of the pathologic arterial branches was performed (Figure 2b,2c). Collateral spleen revascularization was preserved. After the procedure the patient remained asymptomatic, even after two months from discharge.

Dieulafoy's lesion is an unusual cause of gastrointestinal bleeding. The congenital absence of the splenic artery associated with major gastric bleeding was previously described [1]. We hypothesize that spleen revascularization through gastric collaterals caused the development of hypertrophic submucosal vessels that bleed as a result of mucosal erosions. An integrated approach allowed the detection of this unusual lesion and its prompt and effective management.

References

1. Durrans D, Fawcitt RA, Taylor TV. Congenital absence of the splenic artery associated with major gastric bleeding in adolescence. Br J Surg. 1985 Jun;72(6):456-7.

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***Corresponding author:** Greco S, Department of Medicine, Gastrointestinal Unit II, Asst Papa Giovanni XXIII, Bergamo, Italy

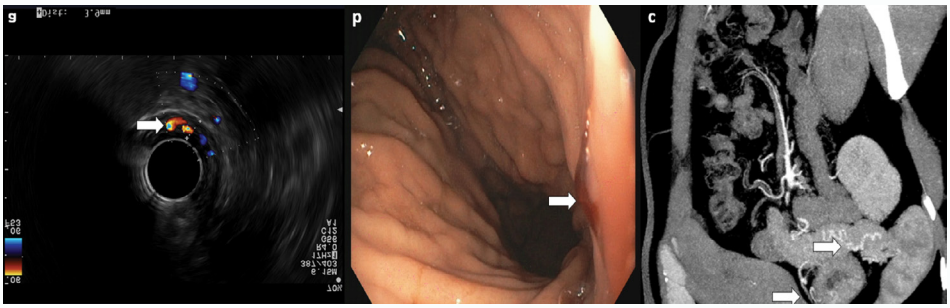

Figure 1: Endoscopic and CT findings. (a) Endo sonography image shows an abnormally large caliber submucosal artery (arrow), with high and pulsatile flow along the small gastric curvature. (b) EGDS photography shows a few-millimeter lesion that emerges the mucosa with oozing; no signs of local inflammation or ulceration are evident. (c) MIP angio-CT image reformatted on the coronal plane shows the absence of the splenic artery and compensatory hypertrophy of pancreatic tail and gastric fundus collaterals (arrows).

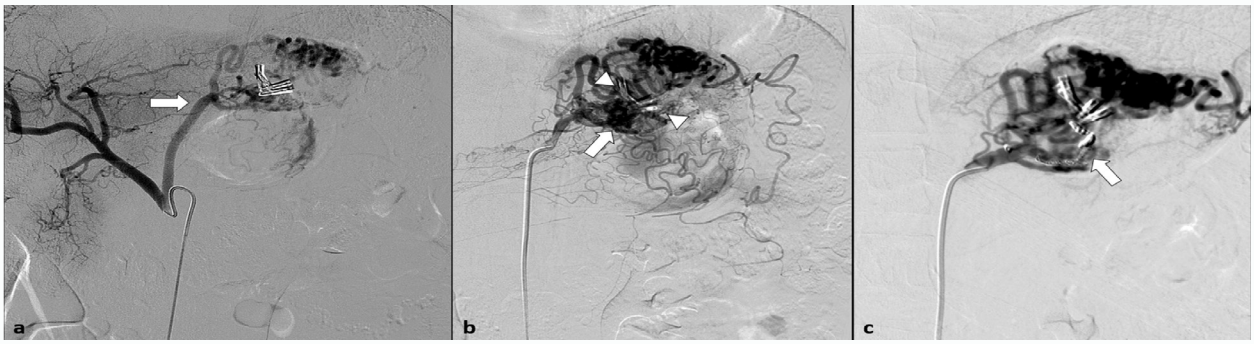

Figure 2: Angiographic procedure. (a) Celiac trunk angiogram shows the absence of the splenic artery with compensatory hypertrophy of the left gastric artery. (b) Selective left gastric angiogram shows opacification of abnormal gastric fundus vessels forming a pathologic hypervascular tangle (arrow) projectively closed to the endoscopic hemoclips (arrowheads). (c) Final angiogram acquired after coil (arrow) embolization confirms devascularization of the Dieulafoy lesion.