When Angiography Makes a Difference - Polyarteritis Nodosa- A Rare Cause of Mid-Gastrointestinal Bleeding

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Introduction

Mid gastrointestinal bleeding (MGIB) is uncommon but represents the majority of cases of recurrent GI bleeding without an obvious source, even after endoscopic and imaging evaluation [1]. Overt MGIB manifestations depend on the rate of bleeding and when associated with hemodynamic instability may present with haematemesis, melaena and/or haematochezia. Five to ten percent of patients with GI bleeding will not have an identifiable source of bleeding after initial endoscopic and imaging evaluation [2]. The advent of push-and-pull enteroscopy, intraoperative enteroscopy and wireless video capsule enteroscopy has shed light on cases which previously could only be diagnosed as occult GI bleeding, allowing for the identification of a bleeding source in the small bowel in up to 75 percent of these patients [3]. MGIB may be caused by multiple aetiologies such as inflammatory bowel disease (IBD), angiodysplasia, Dieulafoy lesions, Henoch-Schönlein purpura to name but a small subset (Table 1). Their relative frequencies in MGIB are not well established but appear to be age-dependent [4].

We present an elusive case of recurrent GI bleeding with severe hemodynamic repercussion where imaging proved essential to elicit a rare diagnosis when all other investigations had failed.

Table 1: Possible aetiologies for mid gastrointestinal bleeding (MGIB).

<table>
<thead>
<tr>
<th>Common causes</th>
<th>Rare causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory bowel disease (under 40 years of age)</td>
<td>Henoch-Schoenlein purpura</td>
</tr>
<tr>
<td>Angiodysplasia (over 40 years of age)</td>
<td>Portal hypertensive enteropathy / small bowel varices</td>
</tr>
<tr>
<td>Dieulafoy lesions</td>
<td>Amyloidosis</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>Blue rubber bleb nevus syndrome</td>
</tr>
<tr>
<td>NSAID users (over 40 years of age)</td>
<td>Osler-Weber-Rendu syndrome</td>
</tr>
<tr>
<td>Meckel's diverticulum (under 40 years of age)</td>
<td>Pseudoxanthoma elasticum Kaposi sarcoma</td>
</tr>
<tr>
<td>Polyposis syndromes (e.g. Lynch) (under 40 years of age)</td>
<td>Plum mer-Vision syndrome Ehler-Danlos syndrome</td>
</tr>
</tbody>
</table>

Abbreviations:
- MGIB: Mid Gastro Intestinal Bleeding
- IBD: Inflammatory Bowel Disease
- GI: Gastro Intestinal
- CTA: CT Angiography
- Hb: Haemoglobin
- VDRL: Venereal Disease Research Laboratory
- TPHA: Treponema Pallidum Hemagglutination Assay
- ANA: Antinuclear Antibodies
- ETV: Entecavir
- ACR: American College of Rheumatology
**Case Report**

We report the case of a 58-year-old male patient of black race with recurrent overt gastrointestinal (GI) bleeding since 2010. The patient has a previous medical history of ischemic heart disease (medicated with acetylsalicylic acid and clopidogrel), essential hypertension (medicated with perindopril and amlodipine), chronic hepatitis B infection without evidence of cirrhosis and latent syphilis (previous treatment). He also had a previous medial laparotomy for unconfirmed suspicion of gastrointestinal stromal tumour. There was no personal or family history of cancer. Since 2010, the patient had multiple hospital admissions with recurrent episodes of GI bleeding characterized by haematemesis, haematochezia and melaena, with hemodynamic repercussion and severely diminishing the patient’s quality of life. During these hospital admissions, multiple and extensive endoscopic and imaging examinations were performed.

Between 2010 and 2012, endoscopic examinations including upper GI endoscopy, push-and-pull enteroscopy and colonoscopy, were all interpreted as normal. Conventional and CT-angiography (CTA) only documented high-density intra-luminal content of the proximal jejunum, interpreted in the context of recent upper GI bleeding, but no evidence of active bleeding. Capsule enteroscopy suggested the presence of a possible sub-mucosal lesion at the level of the proximal jejunum. In 2013, both upper GI endoscopy and push-and-pull enteroscopy reported a likely Dieulafoy lesion in the proximal jejunum. The lesion was treated with 1:10,000 epinephrine, four haemostatic clips and the mucosa was tattooed. In 2013, the patient was admitted with a myocardial acute infarction for which he was submitted to percutaneous coronary angiography and stented, starting dual anti platelet therapy.

In early 2014, the patient was again admitted on three more separate occasions for episodes of haematochezia, with active bleeding being identified from a Dieulafoy lesion in a previously tattooed zone of the proximal jejunum. Two more haemostatic clips were used to treat the acute bleeding. In October of 2014, the patient was again admitted to our hospital for haematochezia with hemodynamic instability. Blood tests showed microcytic anaemia with 5.9g/dL of hemoglobin (Hb). Upper GI endoscopy and colonography failed to identify relevant changes. Complete intra-operative enteroscopy was performed showing blood in the distal ileum but again no lesions. Biopsies performed at the time failed to document microscopic criteria of vasculitis.

During this hospital admission, mesenteric angiography revealed "tortuous parietal gastric arterial branches with reduced calibre and millimetric aneurysmatic focal dilatations with similar changes along the vasa recta of the marginal artery of the colon." (Figure 1). CTA performed after the angiography (Figure 2) confirmed active bleeding with evidence of intraluminal contrast medium (no contrast medium given per mouth) and focal dilatations of the mesenteric circulation. No changes were identified in the renal vessels. A retrospective review of the previous angiographies allowed for the identification of subtle calibre irregularities along the mesenteric vessels with topographic correlation with the aneurysmal dilatations seen in the later scan.

Additional analytical evaluation performed at this time revealed anaemia with 8 g/dL of Hb, elevated C reactive protein (CRP of 1.2 mg/dL) and sedimentation rate (32 mm/h). Review of infection markers revealed viral load for HBV of 8625 copies, positive screening tests for syphilis (Venereal disease research laboratory test [VDRL]; titre of 1:4 and Treponema pallidum hemagglutination assay test [TPHA]; titre of 1:5120) and a positive Strongyloides stercoralis antigen test (result of 1.25). Auto-immune screening...
revealed positive antinuclear antibodies (ANAs) (1:160, midbody). The differential diagnosis at this point in time included Polymyalgia Nodosa (PAN), Strongyloidiasis and Syphilis, all of which could explain micro-aneurysms in the mesenteric circulation. Further investigations included skin biopsy, electromyography and biopsies by upper GI endoscopy and colonoscopy, which were all normal. A lumbar puncture also excluded neurosyphilis. Renal artery Doppler scan and CTA of the brain did not show further vascular changes. Treatment was started with Entecavir (ETV) for HBV infection, penicillin for late latent syphilis and Ivermectin for Strongyloides infection.

In January of 2015, the patient was again admitted for a new episode of haematochezia with haemodynamic instability, progressing to hypovolemic shock.

During the hospital admission, the second episode of haemodynamic instability allowed for imaging and gastroenterological studies to be performed in the acute phase (within 12 hours of the start of symptoms). However, CTA and conventional angiography failed again to report significant changes and complete intra-operative enteroscopy identified blood in the colon but failed to identify any lesion. Clinical haematochezia was only evident after 21 hours of the start of haemodynamic instability. Therapy was started for PAN with methylprednisolone and cyclophosphamide, clopidogrel was suspended (conversion to single antiplatelet therapy) and blood pressure control was optimized.

In February of 2015, one week after starting therapy with cyclophosphamide a new episode of haematochezia with haemodynamic instability occurred with 6 g/dL of Hb with an active bleeding site at the proximal jejunum was confirmed by 99mTc scintigraphy. Exploratory laparotomy identified blood in the proximal jejunum with at least three bleeding points in a 25cm segment, about 20cm distal to the angle of Treitz. A segmental small bowel resection was performed and the histological report documented “focus of haemorrhage in the submucosa and predominantly muscular is propria, associated with inflammatory polymorph nuclear infiltrate of the wall of the arterioles” which is a diagnostic criterion for PAN. In July of 2015, the patient was again admitted for an episode of melaena. Enteroscopy performed in the Emergency department identified a Dieulafoy-like lesion near the surgical anastomosis site by the tattooed mucosa, 30cm from the Treitz angle. Blood clots and low output active bleeding were identified and treated with three haemostatic clips. Presently, 15 months after the presumptive diagnosis of PAN, the patient continues therapy with prednisolone, having completed seven cycles of cyclophosphamide. The last hospital admission for GI bleeding was in July of 2015, eleven months ago. (Table 2) (Figure 3) summarise the bleeding events and gastroenterological and imaging evaluations from 2010 to 2016.

**Table 2:** Summary of events.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>28-10-2010</td>
<td>CTA AP: Normal</td>
</tr>
<tr>
<td>16-11-2010</td>
<td>CTA AP: Normal</td>
</tr>
<tr>
<td>25-2-2012</td>
<td>Hospital admission for haematochezia</td>
</tr>
<tr>
<td>25-2-2012</td>
<td>CTA AP: Normal</td>
</tr>
<tr>
<td>21-3-2012</td>
<td>Hospital admission for haematochezia</td>
</tr>
<tr>
<td>21-3-2012</td>
<td>Emergency upper endoscopy: Normal</td>
</tr>
<tr>
<td>29-3-2012</td>
<td>Angiography: Normal</td>
</tr>
<tr>
<td>18 to 21-2-2013</td>
<td>Hospital admission for new episode of haematochezia and haematemesis</td>
</tr>
<tr>
<td>18-2-2013</td>
<td>Enteroscopy with paediatric colonoscope: Vascular lesion in the proximal jejunum with active bleeding of low output, treated with three haemostatic clips and the mucosa was tattooed</td>
</tr>
<tr>
<td>25-7 to 2-8-2013</td>
<td>Hospital admission for new episode of haematochezia</td>
</tr>
<tr>
<td>25-7-2013</td>
<td>Upper endoscopy: Normal Enteroscopy: Dieulafoy lesion in the proximal jejunum treated with 1:10,000 and four haemostatic clips</td>
</tr>
<tr>
<td>15 to 24-6-2014</td>
<td>Hospital admission for new episode of haematochezia with haemodynamic instability</td>
</tr>
<tr>
<td>15-6-2014</td>
<td>Upper endoscopy and push and pull enteroscopy: Normal</td>
</tr>
<tr>
<td>18-6-2014</td>
<td>Colonoscopy: Normal Wireless videocapsule enteroscopy: Normal</td>
</tr>
<tr>
<td>6 to 16-9-2014</td>
<td>Hospital admission for new episode of haematochezia with haemodynamic instability</td>
</tr>
</tbody>
</table>
Push and pull enteroscopy: Dieulafoy-like lesion near tattooed mucosa without evidence of active bleeding. Treatment with two haemostatic clips.

Hospital admission for new episode of haematochezia with haemodynamic instability

Enteroscopy: Normal

New episode of melena

CTA AP and Angiography: "tortuous parietal gastric arterial branches with diminished caliber and millimetric aneurysmatic focal dilatations with similar changes along the vasa recta of the marginal artery of the colon" Presumptive diagnosis of PAN

Upper endoscopy, enteroscopy and colonoscopy with biopsies: Normal

Start of therapy for HBV with Entecavir

Start of therapy for PAN with Prednisolone

Start of therapy for late latent Syphilis with Penicillin

Start of therapy for Strongyloidiasis with Ivermectin

Hospital admission for new episode of haematochezia with haemodynamic instability

Hospital admission for new episode of haematochezia with progression to hypovolemic shock (Hb- 4.8 g/dL)

Start therapy for PAN with cyclofosfamide

New episode of haemodynamic instability while an inpatient Angiography: Normal

Discussion

By definition, a Dieulafoy lesion is a single tortuous artery in the submucosa and is a potential aetiology for MGIB. We present the argument that, in the present case, the lesion is a manifestation of PAN (an aneurysmal dilatation of a submucosal artery) and as such, the ‘tip of the iceberg’ of the underlying disease. Treating only the lesion with haemostatic clips and not the underlying cause (i.e. inflammation of the arterial wall) did not stop disease progression or bleeding recurrence. PAN is a rare spectrum of diseases characterized by a systemic necrotizing vasculitis affecting medium-sized muscular arteries [5], with an estimated prevalence rate between 2 and 33 per million [6]. The kidneys, skin, joints, muscles, nerves and GI tract may be involved, while sparing of the lung is noticeable. In this case of recurrent and overt MGIB, multiple gastroenterological and imaging evaluations had failed to conclusively identify the source of bleeding or, when a Dieulafoy-like lesion was identified and treated, failed to significantly affect the course of the disease. This led to an increase in the number and severity of bleeding events accompanied by haemodynamic instability and even hypovolemic shock.

A new diagnostic pathway was opened when microaneurysmatic dilatations were diagnosed. The patient presented...
Strongyloidiasis, late latent syphilis and chronic HBV infection, which is associated with PAN [7], and all three of these diseases could explain the micro-aneurysmal dilatations in the mesenteric and splanchnic arteries. Empirical treatment was initiated for all these diseases and eventually, the histological report from the segmental resection of proximal jejunum confirmed PAN (isolated GI manifestation). In PAN, inflammatory cells infiltrate along the arterial wall predisposes to narrowing, thrombosis and aneurysm formation. These changes can be identified on angiographic evaluations although they may be subtle and easily overlooked, as happened on all but one of the angiographies. An inter-hospital MDT consensus was needed to confirm the presence of micro aneurysms in all angiographies and to establish a presumptive diagnosis of PAN by fulfilling the minimum of three out of ten of the American College of Rheumatology (ACR) 1990 criteria. These criteria were: diffuse myalgias and weakness of muscles; the presence of hepatitis B surface antigen and arteriogram showing aneurysms or occlusions of the visceral arteries, not due to arteriosclerosis, fibro muscular dysplasia or other non-inflammatory causes. Later, the histological changes further added another ACR criterion for the diagnosis. Treatment with steroids and cyclophosphamide has not prevented recurrence of MGIB although it has clearly reverted the accelerated rate of deterioration that the patient was experiencing.

**Conclusion**

Assessments of the whole GI tract is now possible with endoscopic techniques such as upper endoscopy, colonoscopy, and push and pull enteroscopy, intraoperative enteroscopy and wireless video capsule enterography but imaging evaluation still provides an essential tool to assess vascular causes of MGID. In the presented case report subtle changes on angiography provided the diagnostic clues for the elusive final diagnosis and effective treatment.

**References**


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