A Rare Cause of Gastrointestinal Bleeding: Jejunal Diverticulosis

Sir,

Jejunal diverticulosis is an acquired condition which is rarely encountered. It has been detected in 2.0 - 2.3% of enteroclysis cases and in 1.3 - 4.6% of autopsies.1 Arteriovenous malformations, colonic diverticulosis, internal hemorrhoids, and cancers account for about 95% of lower gastrointestinal tract bleedings. Other conditions, rarely observed to cause these bleedings, may lead to difficulties in diagnosis and treatment. Here, a case of jejunal diverticulosis, which is a rare cause of the lower gastrointestinal tract bleeding, is presented.

A 59-year man presented to the hospital with a lower gastrointestinal system bleeding lasting for three days. History showed that it was in the form of melana at the onset and then changed into fresh rectal bleeding as hematochezia. On admission, hemoglobin and hematocrit were 6.5 g/dl and 18%, respectively.

On esophagoduodenoscopy, colonoscopy and computed tomography, there were no hemorrhagic sites. Despite infusion of seven units of blood, hemoglobin could only be increased to 7.5 g/dl. Then, the patient underwent mesenteric angiography and bleeding scintigraphy. These showed no hemorrhagic foci. Since hematocrit continued to decrease, laparotomy was performed. During surgery, jejunal diverticula occasionally filled with hematoma and starting on 30cm distal part of Treitz ligament and extending 30cm in length (Figure 1). Segmental resection of the intestines and end-to-end anastomosis were performed. The patient had no postoperative problems and was discharged on the fourth day after the operation.

Small bowel diverticulosis is rarely encountered. In fact, it has been shown to appear in the duodenum in 0.02% to 6%, and in the jejunoleum in 0.07% to 1%, of patients by using contrast examination.2 Chronic abdominal symptoms such as pain, nausea, steatorrhea, and malabsorption might be due to small bowel diverticula. However, acute symptoms like diverticulitis, intestinal perforation, small bowel obstruction, and hemorrhage may indicate jejunal diverticula.3

Acute gastrointestinal hemorrhage is primarily managed by conservative medical therapy followed by diagnostic enteroscopy and finally surgery. However, enteroscopy may not show the bleeding foci in 10% - 20% of the cases although bowel cleansing was performed appropriately. Computed tomography-angiography has a sensitivity of 85.2% and specificity of 92.1% in detection of active acute intestinal bleeding.4 Multi-detector computed tomography angiography with advanced three dimensional applications are used to determine bleeding sites. Push and capsule enteroscopy can be used to detect persistent but moderate bleeding from an obscure site. If these tests are inconclusive, (99m)Tc labelled erythrocyte scintigraphy should be performed. If any bleeding is detected, angiography should be carried out to determine the exact location of the bleeding.5

It is still challenging to make the diagnosis of jejunal diverticulosis since diagnostic tools may fail to corroborate it. Definitive diagnosis of complicated diverticulosis jejunum can only be made during surgery. Regular diagnostic tests can be inadequate to diagnose patients with an obscure gastrointestinal bleeding, and cases of severe bleeding may need a surgical intervention.

REFERENCES

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