Scholars Journal of Medical Case Reports
Abbreviated Key Title: Sch J Med Case Rep
ISSN 2347-9507 (Print) | ISSN 2347-6559 (Online)
Journal homepage: https://saspublishers.com

OPEN ACCESS

Medical Science

Upper Gastrointestinal Hemorrhage Revealing Cameron Lesions: A Case Report

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DOI: https://doi.org/10.36347/sjmcr.2025.v13i06.033 | **Received:** 24.04.2025 | **Accepted:** 30.05.2025 | **Published:** 17.06.2025

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Abstract | **Case Report**

Upper gastrointestinal hemorrhage (UGIH) is a frequent emergency in gastroenterology, with a variety of etiologies. We report the case of a 79-year-old patient, with a history of unoperated tight aortic stenosis and recent ischemic stroke on Kardegic, admitted for massive hematemesis complicated by hemorrhagic shock. An oesogastroduodenal fibroscopy revealed a 4 cm sliding hiatal hernia, complicated by severe Los Angeles grade D oesophagitis and Cameron lesions. Medical management resulted in clinical stabilization, with a scheduled follow-up FOGD at 8 weeks. This case highlights the importance of considering Cameron lesions as a potential cause of HDH, particularly in elderly patients with hiatal hernia.

Keywords: Upper gastrointestinal hemorrhage (UGIH), Cameron lesions, Hiatal hernia, Elderly patient, Esophagitis

INTRODUCTION

Upper GI hemorrhage (UGIH) is a frequent gastroenterological emergency, with significant morbidity and mortality, particularly in elderly and comorbid patients. Classic causes include peptic ulcers, esophageal varices and severe esophagitis. Cameron lesions, often under-diagnosed, are linear erosions located at the neck of hiatal hernias, which can be complicated by hemorrhage. We report an illustrative case.

CLINICAL OBSERVATION

A 79-year-old patient with a history of unoperated aortic stenosis and ischemic stroke 6 months ago on Kardegic was admitted urgently with profuse hematemesis and hemorrhagic shock.

On admission, clinical examination revealed a conscious, hemodynamically unstable patient (BP: 80/60 mmHg, HR: 123 bpm), with a rectal examination showing melena.

Biological tests showed normocytic normochromic anemia with a BH level of 9.7 mg/dl.

Initial management included vascular filling, administration of noradrenaline (2 µg/kg/min), an 80 mg bolus of proton pump inhibitors (PPIs) followed by continuous infusion (8 mg/h), and transfusion of packed red blood cells.

After hemodynamic stabilization and an 8-hour fast, an esogastroduodenal fibroscopy (FOGD) was performed, revealing a 4 cm sliding hiatal hernia complicated by Cameron ulcerations and severe grade D esophagitis according to the Los Angeles classification.

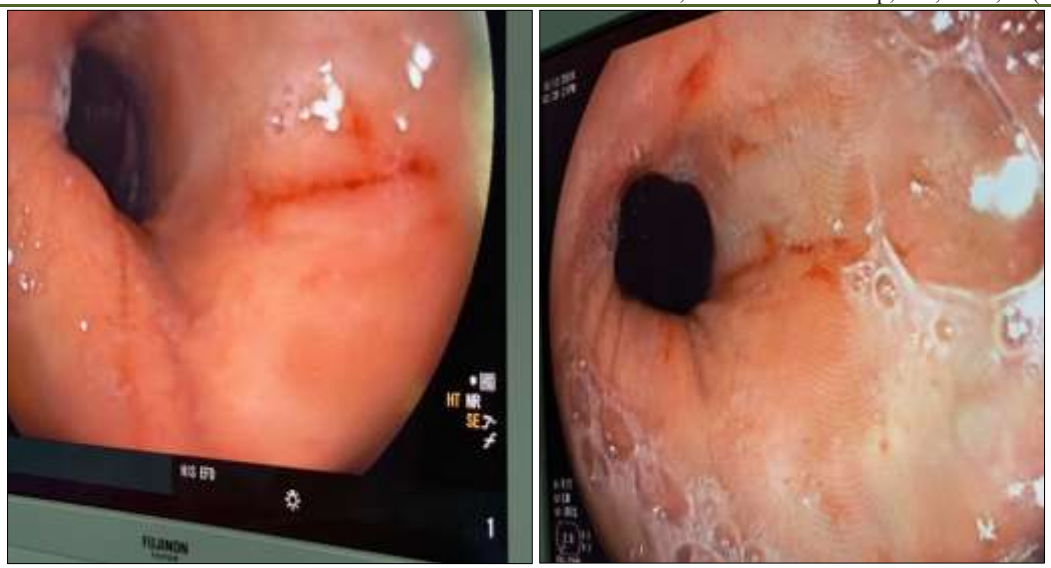

Figure 1: endoscopic view showing hiatal hernia complicated by Cameron lesions

Treatment with intravenous PPI was continued for 5 days, followed by an oral relay. The clinical course was favorable, with hemodynamic stabilization and progressive correction of the anemia. A follow-up FOGD showed healing of Cameron lesions.

DISCUSSION

Les lésions de Cameron, décrites initialement par Cameron et Higgins en 1986, sont des érosions ou ulcérations linéaires localisées au collet d'une hernie hiatale. Leur fréquence est estimée entre 5 et 20 % chez les patients porteurs d'hernie hiatale explorés en endoscopie, bien qu'elles soient souvent sous-diagnostiquées, notamment en l'absence de saignement actif [1]. Ces lésions sont provoquées par un effet mécanique de friction et de cisaillement de la muqueuse gastrique contre le diaphragme, amplifié par les mouvements respiratoires, les changements de pression intra-abdominale et parfois une ischémie locale [2].

Chez les patients sous antiagrégants plaquettaires, comme c'était le cas de notre patient, la fragilité vasculaire et muqueuse favorise l'apparition d'hémorragies massives à partir de ces lésions, justifiant une vigilance accrue [3].

Treatment is classically based on hemodynamic stabilization, discontinuation of antiaggregants or anticoagulants if possible, administration of high-dose proton pump inhibitors (PPIs), combined with correction of iron deficiency in cases of chronic anemia [4].

However, the most recent data, including a systematic review and meta-analysis published in 2020, underline that in the event of failure of medical treatment or recurrence, surgical management - in particular laparoscopic fundoplication - offers significantly superior results in terms of hemorrhagic control and remission of anemia. According to this analysis, 92% of patients who underwent surgical repair showed durable healing, compared with 67.2% under medical treatment alone [5]. These data are in line with current recommendations, which call for individualization of treatment strategy according to the patient's condition and bleeding risk [6].

In the reported case, the favorable evolution under medical treatment with PPI, transfusion correction and hemodynamic stabilization justifies endoscopic monitoring by FOGD control at 8 weeks, and subsequent therapeutic re-evaluation according to clinical evolution.

CONCLUSION

This case illustrates a severe and rare presentation of upper GI hemorrhage due to the coexistence of advanced-grade esophagitis and Cameron lesions within a hiatal hernia. Recognition of this often underestimated presentation is essential for prompt and appropriate management.

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