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Digestive Endoscopy

Massive Gastrointestinal Bleeding from a Dieulafoy Lesion Located within a Hiatal Hernia Sac: A Diagnostic Challenge

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Abstract **Case Report**

Dieulafoy lesions are an uncommon cause of acute gastrointestinal bleeding and are typically located in the proximal stomach. Localization within a hiatal hernia sac is exceptionally rare and may lead to diagnostic delay. We report a case of massive upper gastrointestinal bleeding originating from a Dieulafoy lesion located at the neck of a hiatal hernia, initially missed during endoscopic evaluation. A 56-year-old North African woman undergoing evaluation for operable cholangiocarcinoma presented with acute massive upper gastrointestinal bleeding manifested by abundant hematemesis. On admission, the patient was hemodynamically stable but symptomatic, prompting urgent endoscopic evaluation. Initial upper endoscopy was negative despite ongoing bleeding. A second emergency endoscopy performed revealed diffuse oozing within a confirmed hiatal hernia. After extensive lavage, contact between the endoscope and a small mucosal defect triggered pulsatile arterial bleeding consistent with a Dieulafoy lesion located at the hernia neck. Immediate hemostasis was achieved using a standard through-the-scope hemostatic clip. No rebleeding occurred during hospitalization. This case highlights the importance of meticulous inspection of the hiatal hernia sac during emergency endoscopy, particularly after an initially negative examination, as occult Dieulafoy lesions may cause life-threatening bleeding

Keywords: Dieulafoy, gastrointestinal bleeding, hiatal hernia, upper endoscopy, diagnostic challenge.

INTRODUCTION

Acute upper gastrointestinal bleeding is a common medical emergency with potentially severe outcomes. While peptic ulcer disease is the most frequent cause, rare vascular lesions such as Dieulafoy lesions should be considered, especially when initial endoscopy is negative.

We report a rare case of a Dieulafoy lesion located at the neck of a hiatal hernia, initially missed on endoscopy, highlighting the diagnostic challenges and the importance of careful reassessment in unexplained upper gastrointestinal bleeding.

CASE REPORT

A 56-year-old North African woman with operable cholangiocarcinoma under preoperative evaluation presented with acute massive upper gastrointestinal bleeding manifested by sudden and abundant hematemesis. On admission, she was conscious and hemodynamically stable but symptomatic, prompting urgent endoscopic assessment.

An initial upper gastrointestinal endoscopy was performed emergently but failed to identify an active bleeding source, despite the presence of blood within the upper digestive tract. In view of persistent clinical suspicion of ongoing bleeding, a second emergency endoscopy was performed shortly thereafter.

During the second examination, a hiatal hernia was identified. The hernia sac contained fresh blood with diffuse oozing, initially limiting adequate visualization. Extensive lavage and suctioning were required to clear the endoscopic field. Careful inspection subsequently revealed a small mucosal defect at the neck of the hiatal hernia. Minimal contact with this area using the endoscope induced immediate pulsatile arterial bleeding, consistent with a Dieulafoy lesion.

A diagnosis of Dieulafoy lesion located at the hiatal hernia neck was made. Endoscopic hemostasis was

immediately achieved using a through-the-scope hemoclip, resulting in complete and durable cessation of bleeding. The procedure was completed without complications.

The patient remained clinically stable after the intervention, with no recurrence of gastrointestinal bleeding during hospitalization. She was discharged in good condition with planned follow-up.

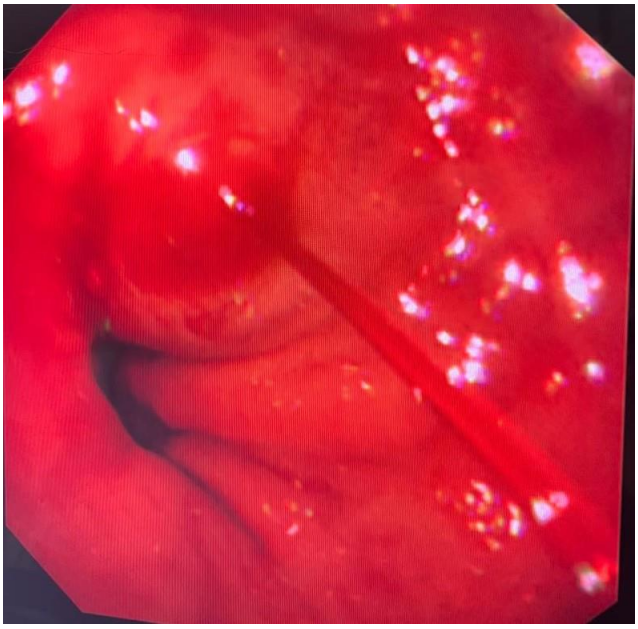

Figure 1: Endoscopic visualization of active spurting arterial bleeding

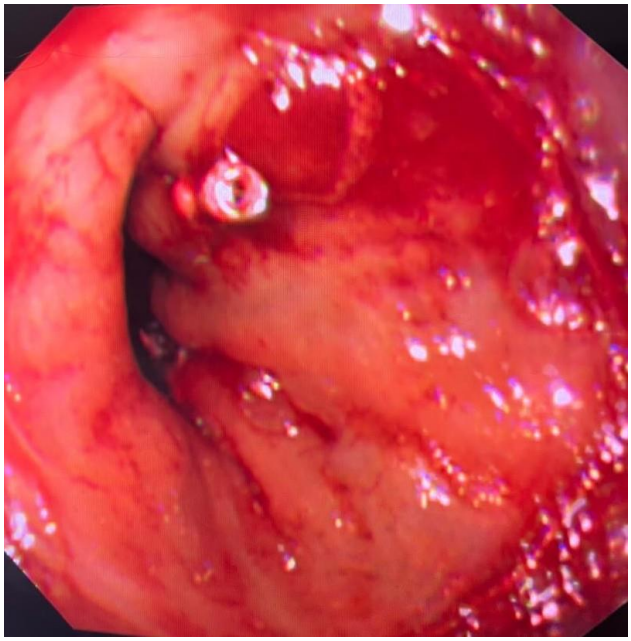

Figure 2: Endoscopic image after placement of a hemostatic clip and successful control of bleeding

DISCUSSION

Dieulafoy lesions represent an uncommon but clinically significant cause of acute upper gastrointestinal bleeding, accounting for approximately 1%–2% of cases, but they may lead to sudden and massive hemorrhage with significant clinical consequences (Khan *et al.,* 2015; Kusnik *et al.,* s. d.).

They are characterized by a large-caliber submucosal artery exposed through a minimal mucosal defect without surrounding ulceration, which explains the occurrence of severe bleeding in the absence of clear endoscopic lesions (Khan *et al.,* 2015; Losurdo *et al.,* s. d.).

Due to these anatomical features, diagnosis can be particularly challenging in emergency settings, especially when active bleeding, clots, or poor visibility limit endoscopic assessment (Al-Busaidi *et al.,* 2023; Losurdo *et al.,* s. d.). Initial endoscopy may therefore fail

to identify the bleeding source in a significant proportion of cases, making repeat endoscopy an essential step when clinical suspicion remains high (Losurdo *et al.,* s. d.). Intermittent bleeding, suboptimal visualization, and localization within mucosal folds are well-recognized causes of missed diagnosis during the first examination(Losurdo *et al.,* s. d.).

This diagnostic difficulty was clearly illustrated in our patient, in whom the initial endoscopy was negative despite ongoing hematemesis. The need for a second emergency examination aligns with previous observations emphasizing that persistent or unexplained bleeding should prompt early reassessment rather than exclusion of an endoscopically treatable source(Kusnik *et al.,* s. d.).

Although Dieulafoy lesions most commonly occur along the proximal lesser curvature of the stomach near the gastroesophageal junction, they have also been described in multiple extra-gastric and atypical locations throughout the gastrointestinal tract (Al-Busaidi *et al.,* 2023; Kusnik *et al.,* 2023). The existence of these unusual sites may further contribute to diagnostic delay, particularly when lesions are hidden within complex anatomical structures.

In the present case, the lesion was located at the neck of a hiatal hernia, an exceptionally uncommon site that likely contributed to the initially negative examination. Hiatal hernia anatomy may retain blood and clots, significantly impairing visualization during emergency endoscopy (*Dieulafoy lesions and gastrointestinal bleeding: Baylor University Medical Center Proceedings: Vol 33, No 4*, s. d.). To the best of our knowledge, Dieulafoy lesions arising from the hiatal hernia neck have been rarely reported, making this presentation a notable diagnostic pitfall(Al-Busaidi *et al.,* 2023; *Dieulafoy lesions and gastrointestinal bleeding: Baylor University Medical Center Proceedings: Vol 33, No 4*, s. d.).

A striking feature in our case was the occurrence of pulsatile arterial bleeding immediately after minimal endoscopic contact with the lesion. This is consistent with the known pathophysiology of Dieulafoy lesions, where a persistently large-caliber artery lies directly beneath a nearly normal mucosa and can be easily disrupted, resulting in abrupt arterial hemorrhage (Losurdo *et al.,* s. d.). Extensive lavage was crucial for lesion identification, highlighting the importance of meticulous cleaning and repeated inspection in cases of unexplained upper gastrointestinal bleeding (Losurdo *et al.,* s. d.).

Once identified, endoscopic therapy remains the first-line treatment, achieving high rates of immediate hemostasis (Kusnik *et al.,* 2023; Losurdo *et al.,* s. d.). Among available modalities, mechanical hemostasis using hemoclips is particularly effective, as it provides immediate vessel compression and is associated with lower rebleeding rates compared with injection therapy alone (Losurdo *et al.,* s. d.). In our patient, prompt placement of a through-the-scope clip achieved rapid and durable hemostasis despite emergency conditions and difficult anatomical access.

Although endoscopic treatment has greatly improved outcomes, rebleeding may still occur when lesions are not fully visualized or adequately treated, emphasizing the importance of precise localization before intervention (Kusnik *et al.,* 2023; Losurdo *et al.,* s. d.). In our case, no recurrence of bleeding was observed during hospitalization, supporting the effectiveness of properly applied mechanical hemostasis.

Taken together, this case highlights several important clinical lessons. In patients with unexplained upper gastrointestinal bleeding, careful inspection of the hiatal hernia sac should be systematically performed, particularly after an initially negative endoscopy. Awareness of atypical Dieulafoy lesion locations, combined with thorough lavage and repeated inspection, may reduce diagnostic delay and prevent life-threatening recurrent hemorrhage.

CONCLUSION

Dieulafoy lesions remain a rare but important cause of acute upper gastrointestinal bleeding and may be difficult to diagnose when located in atypical anatomical sites. This case demonstrates that a Dieulafoy lesion arising from the neck of a hiatal hernia may remain occult during initial endoscopic evaluation and become evident only after careful lavage and repeat examination. Prompt mechanical hemostasis using endoscopic clipping allowed rapid and durable bleeding control despite emergency conditions. Systematic inspection of the hiatal hernia sac should therefore be considered during evaluation of unexplained upper gastrointestinal bleeding to avoid diagnostic delay and prevent potentially life-threatening recurrence.

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