

Upper Gastrointestinal Bleeding Secondary to Hematidrosis: A Case Report

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Abstract

Case Report

Hematidrosis, also reported as hematohidrosis, is an exceedingly rare condition in which blood or blood-stained fluid is discharged through intact skin, most often from the face, the scalp or the flexural folds, and usually in relation to intense emotional stress. Fewer than one hundred well-documented observations have been published, and involvement of mucosal surfaces bloody tears, blood-stained ear discharge, epistaxis or bleeding from the oral cavity is described in a minority of them. Digestive presentations are exceptional and, when they occur, they raise the difficult question of whether the blood arises from a true gastrointestinal lesion or from the disease itself. We report the case of a 21-year-old woman with hematidrosis diagnosed at the age of twelve, at that time after recurrent epistaxis, whose diagnosis had been established at the age of twelve after recurrent epistaxis and blood-stained saliva, and who presented to the emergency department with repeated episodes of low-volume haematemesis. She was conscious and well oriented and remained haemodynamically stable, with a systolic blood pressure of 130 mmHg and a mean arterial pressure of 70 mmHg, but with sinus tachycardia at 120 beats per minute; the respiratory rate was 14 breaths per minute, peripheral oxygen saturation was 99% on room air and the abdomen was soft and non-tender. A cutaneous bleeding episode was witnessed during the stay in the emergency department. The full blood count showed no anaemia and a normal platelet count, the prothrombin time and the international normalised ratio were normal, and the D-dimer concentration was moderately raised. She received peripheral venous access, high-dose intravenous proton pump inhibitor therapy, tranexamic acid 1 g by slow intravenous infusion and intravenous fluids, and was kept fasting pending endoscopy. Upper gastrointestinal endoscopy demonstrated erythematous gastritis, with no ulcer, no varices and no identifiable source of bleeding. The patient was monitored for 48 hours in the short-stay observation unit, no bleeding recurred and she was discharged home. Haematemesis in a patient with known hematidrosis should therefore be interpreted with caution: endoscopy remains indispensable to exclude a treatable lesion, but a normal or non-specific examination does not rule out the diagnosis and should redirect attention towards the underlying condition rather than towards escalating invasive investigations.

Keywords: hematidrosis; hematohidrosis; sweating blood; haematemesis; upper gastrointestinal bleeding; erythematous gastritis; emergency medicine; case report.

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INTRODUCTION

Hematidrosis, also written hematohidrosis, is defined as the discharge of blood or of blood-stained fluid through intact, unbroken skin, in the absence of any wound or of any identifiable local lesion [1,2]. Described since antiquity and long regarded as legend, the condition was placed on a clinical footing by Holoubek and Holoubek, who reviewed the published observations and proposed the classification that is still used today [1]. It remains exceptionally rare: a recent systematic review

identified only a few dozen adequately documented cases in the modern literature [5].

The pathophysiology is still debated. Histopathological studies have shown erythrocytes within the eccrine ducts and the dermal sweat gland apparatus, with no vasculitis and no primary defect of haemostasis, suggesting a transient passage of blood from the peri-glandular capillary network into the excretory ducts [3,4]. A neurovascular mechanism, triggered by intense sympathetic activation and mediated

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by vasoconstriction followed by capillary rupture, is the most widely accepted hypothesis, and is indirectly supported by the reported efficacy of beta-blockade in several patients [4,6].

The clinical spectrum is not limited to the skin. Bloody tears, blood-stained ear discharge, epistaxis and bleeding from the oral cavity have all been reported, either in isolation or in association with cutaneous episodes, which indicates that mucosal surfaces may be involved by the same process [7-10]. Digestive manifestations, in contrast, are exceptional: to our knowledge, a single observation has associated hematomatosis and hemolacria with gastrointestinal bleeding, and in that patient endoscopy revealed diffuse mucosal lesions ultimately attributed to immunoglobulin A vasculitis [11].

Upper gastrointestinal bleeding is one of the most frequent emergencies in gastroenterology, and its management is codified: risk stratification, acid suppression and upper endoscopy within twenty-four hours in order to identify and treat the responsible lesion [13,14]. This framework, however, presupposes that a lesion exists. When haematemesis occurs in a patient with a rare systemic cause of bleeding, and when endoscopy is normal or shows only non-specific changes, the clinician is left with an apparent contradiction between an unquestionable bleeding episode and an unremarkable examination.

We report the observation of a young woman with long-standing hematomatosis admitted for repeated haematemesis, in whom upper endoscopy showed only erythematous gastritis. The aim of this report is to draw attention to a digestive presentation of an exceptional condition, and to discuss how far the diagnostic work-up

should be pushed once a treatable endoscopic lesion has been excluded.

CASE PRESENTATION

A 21-year-old woman presented to the emergency department in June 2026 for repeated episodes of haematemesis of low volume. She was known to have hematomatosis. The diagnosis had been made at the age of twelve, when she was investigated for recurrent epistaxis and for saliva tinged with blood; according to the patient, the work-up carried out at that time included genetic testing, but those reports were not available during the present admission. She had never received any maintenance treatment for the condition. She reported no non-steroidal anti-inflammatory drug intake, no anticoagulant or antiplatelet therapy, no alcohol consumption and no previous digestive disease.

On admission the patient was conscious, well oriented and cooperative. She remained haemodynamically stable, with a systolic blood pressure of 130 mmHg and a mean arterial pressure of 70 mmHg, but she was tachycardic, with a regular heart rate of 120 beats per minute. She was eupnoeic, with a respiratory rate of 14 breaths per minute and a peripheral oxygen saturation of 99% on room air. She was afebrile. The abdomen was soft and non-tender, with no hepatomegaly, no splenomegaly and no sign of portal hypertension. The conjunctivae were not pale and there was no jaundice, no purpura and no mucocutaneous bleeding site other than the episode described below.

During the stay in the emergency department a spontaneous cutaneous bleeding episode was witnessed by the medical team: droplets of blood appeared through intact skin, without any wound, and stained the bed linen (Figure 1).

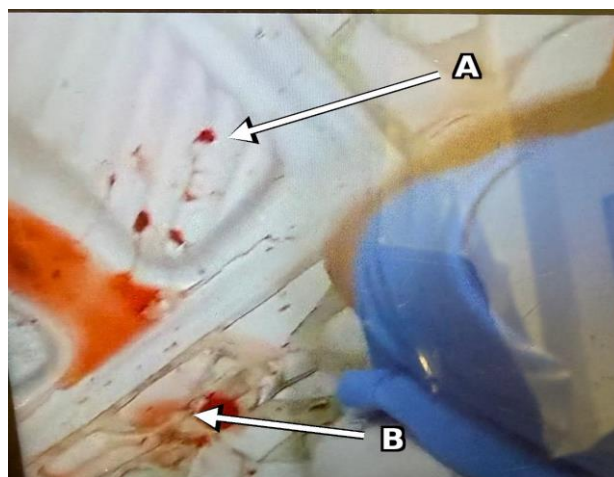


Figure 1: Spontaneous cutaneous bleeding episode witnessed in the emergency department (arrows A and B). Arrow A indicates droplets of blood that appeared through intact skin and stained the bed linen; arrow B indicates a fresh drop of blood collected at the end of the episode. The gloved hand of the examining physician is visible on the right. No wound, no puncture site and no skin lesion was present in the bleeding area. The photograph has been cropped so that no element allowing identification of the patient is visible.

Laboratory investigations performed on admission showed neither anaemia nor thrombocytopenia, together with a mild neutrophil leucocytosis. The prothrombin time and the international

normalised ratio were strictly normal, whereas the D-dimer concentration was moderately raised; the complete results are presented in Table 1.

Table 1: Laboratory results on admission

Laboratory test (unit)	Patient value	Reference interval
RBC (million per microlitre)	4.33	4.00-5.20
Haemoglobin (g/dL)	13.2	12.0-16.0
Haematocrit (%)	41	36-46
MCV (fL)	94.8	80-100
MCH (pg)	30.4	27-33
MCHC (g/dL)	32.1	32-36
Leucocytes (per microlitre)	10,900	4,000-10,000
Neutrophils (per microlitre)	6,550 (60.2%)	1,800-7,000
Eosinophils (per microlitre)	150 (1.4%)	50-500
Basophils (per microlitre)	50 (0.5%)	0-100
Lymphocytes (per microlitre)	3,250 (29.9%)	1,000-4,000
Monocytes (per microlitre)	870 (8.0%)	200-1,000
Platelets (per microlitre)	247,000	150,000-400,000
Prothrombin time (%)	100	70-100
International normalised ratio	1.0	0.8-1.2
D-dimer (mg/L fibrinogen equivalent units)	0.92	< 0.50

Samples were obtained on admission to the emergency department. The full blood count was performed on whole blood collected on ethylenediaminetetraacetic acid using an Alinity hq analyser, and the coagulation tests on citrated plasma using an ACL TOP analyser. Reference intervals are those of the National Mohammed VI Laboratory of Medical Analyses, Rabat, for an adult woman under 50 years of age. Differential leucocyte counts are given as absolute values, with the corresponding percentage in parentheses. RBC: red blood cell count; MCV: mean corpuscular volume; MCH: mean corpuscular haemoglobin; MCHC: mean corpuscular haemoglobin concentration; fL: femtolitres; g/dL: grams per decilitre; mg/L: milligrams per litre; pg: picograms.

Upper gastrointestinal endoscopy was performed during the same admission, after initial stabilisation. It showed erythematous gastritis, with no ulcer, no erosion with a visible vessel, no oesophageal or gastric varices, no Mallory-Weiss tear and no active bleeding; the oesophagus and the duodenum were normal. No biopsy was taken, and the conclusion of the gastroenterologist was that of erythematous gastritis alone, with no lesion capable of accounting for the haematemesis.

Initial management in the emergency department consisted of peripheral venous access, high-dose intra-venous proton pump inhibitor therapy, tranexamic acid 1 g administered by slow intravenous infusion and intravenous fluid rehydration. The patient was kept fasting pending upper gastrointestinal endoscopy, and no blood product was required. She was admitted to the short-stay observation unit of the

emergency department for clinical and biological monitoring.

The patient was monitored in the short-stay observation unit for 48 hours. The course was favourable: there was no recurrence of haematemesis and no further bleeding episode, the haemodynamic status remained stable and she was discharged home after 48 hours.

DISCUSSION

Hematidrosis is a diagnosis of exclusion, and it is above all a clinical diagnosis: blood appears through skin that is demonstrably intact, in the absence of any wound, and the episodes are typically brief, self-limited and precipitated by fear, anxiety or physical exhaustion [1,2]. Our patient had a long-standing diagnosis, first considered in childhood in a context of recurrent epistaxis and blood-stained saliva, and the episode witnessed in the emergency department (Figure 1) reproduced the classical description.

The histopathological work that has been carried out in this condition is remarkably consistent. Manonukul *et al.* found erythrocytes within the eccrine sweat ducts and around the glandular coils, without vasculitis, without thrombosis and without any structural abnormality of the vessel walls [3]. Uber *et al.* reached similar conclusions and emphasised the absence of any coagulation defect [4]. The systematic review by Carrion-Alvarez *et al.* confirmed that the great majority of reported patients have a strictly normal haemo-static work-up [5], which is in keeping with the findings in our patient (Table 1). This point is essential in the emergency

department: a normal full blood count and a normal coagulation profile do not argue against the diagnosis, they are what is expected.

Two findings deserve comment. Sinus tachycardia at 120 beats per minute contrasted with an otherwise reassuring haemodynamic status; in a young patient it is best interpreted as the combined effect of the anxiety that classically accompanies these episodes and of the bleeding itself, and it is precisely the kind of isolated abnormality that should prevent a bleeding episode from being dismissed as trivial. The moderate rise in D-dimer concentration is non-specific: it reflects activation of fibrinolysis in the presence of extravascular blood and, in the absence of any clinical suspicion of venous thromboembolism, it does not by itself justify further imaging.

The proposed mechanism is neurovascular. Intense sympathetic stimulation is thought to produce vaso-constriction of the peri-glandular capillary network followed by capillary rupture, allowing blood to enter the excretory ducts and to be expelled with sweat [4]. The therapeutic response to propranolol reported by Wang *et al.* supports this hypothesis and is one of the few treatments with documented efficacy [6]. Our patient had never received any maintenance treatment, and the recurrence of bleeding episodes at a mucosal site is an argument for discussing beta-blockade with her, together with the identification and management of emotional triggers.

Extracutaneous involvement is what makes the present observation possible. Hemolacria has been reported in association with cutaneous episodes by Praveen and Vincent [7], blood-stained sweaty ear discharge by Tshifularo in a series of four patients [9], and Corrà *et al.* described bleeding originating from the oral cavity [10]. Biswas *et al.* also documented mucosal bleeding sites in their patient [8]. Taken together, these observations indicate that the process is not confined to the eccrine glands of the skin and that mucous membranes may bleed in the same way, which provides a plausible pathway for blood to reach the upper digestive tract, whether it is swallowed after originating in the oral or nasal mucosa or produced by the gastric mucosa itself. This pathway is particularly relevant in our patient, whose disease had manifested from the outset through mucosal bleeding recurrent epistaxis and blood-stained saliva so that a digestive presentation ten years later appears as an extension of a phenotype that had been mucosal from childhood.

Only one previous report has associated hematomatidrosis with digestive bleeding. Gião Antunes *et al.* described a patient with hematomatidrosis and hemolacria who developed haematemesis; in that case, however, endoscopy revealed diffuse mucosal redness, ring-like petechiae, submucosal haemorrhages and superficial ulcerations of the gastric body, the antrum and the

duodenum, and the final diagnosis was immunoglobulin A vasculitis with mesangial deposits [11]. Our observation differs on this decisive point: endoscopy showed only erythematous gastritis, without ulceration, without petechial pattern and without any lesion that could account for the bleeding, and no argument for a systemic vasculitis was found. To our knowledge, haematemesis with a non-contributory upper endoscopy has not previously been described in hematomatidrosis.

This configuration raises a difficult differential diagnosis, which must be addressed explicitly before the bleeding is attributed to the underlying disease. Erythematous gastritis is a frequent and non-specific endoscopic finding, and it is not in itself a sufficient explanation for haematemesis. A constitutional or acquired haemostatic disorder must be excluded, as must a factitious disorder and autoerythrocyte sensitisation syndrome, in which recurrent, painful ecchymotic lesions occur after an emotional trigger and which shares with hematomatidrosis a strong psychological component and a normal haemostatic work-up [12]. In our patient the childhood diagnosis had already been established after a full haematological assessment, and the episode witnessed in the emergency department, with blood appearing through intact skin under direct medical observation, argues strongly against a factitious mechanism.

The management of upper gastrointestinal bleeding is codified by the American College of Gastroenterology and by the European Society of Gastrointestinal Endoscopy: risk stratification on admission, acid suppression, and upper endoscopy within twenty-four hours in order to identify and treat the responsible lesion [13,14]. Validated tools such as the Glasgow-Blatchford score identify patients at low risk of requiring haemostatic intervention [15]. Our patient corresponded to this low-risk profile preserved blood pressure, absence of anaemia, normal platelet count, normal coagulation screen and low-volume bleeding and the favourable course, with no recurrence over 48 hours of monitoring and no need for transfusion or endoscopic haemostasis, confirmed it retrospectively. The value of endoscopy in her case was not therapeutic but diagnostic: it was performed to exclude a treatable lesion, and that objective was achieved. The essential message is that a negative endoscopy in such a patient should not lead to an escalation of invasive investigations, but should return attention to the known underlying condition, to the identification of the emotional triggers and to the specific management of hematomatidrosis. In practical terms, once a treatable lesion has been excluded, a reasonable approach in this setting combines a short course of acid suppression, a period of observation long enough to confirm that bleeding does not recur, explicit reassurance of a patient who has often been investigated repeatedly since childhood, the identification of the emotional and physical triggers of the episodes, access to

psychological support, and scheduled outpatient review at which maintenance beta-blockade can be discussed.

This observation has several limitations. It concerns a single patient, and the causal relationship between hematomidrosis and the haematemeses remains one of exclusion rather than one that has been demonstrated: no bleeding gastric or oropharyngeal mucosal site was visualised at the time of an episode. No gastric biopsy was taken during the endoscopy, so that the histology of the mucosa could not be examined and the *Helicobacter pylori* status remains unknown; both would have been useful, since erythematous gas-tritis is a non-specific finding. Finally, the reports of the work-up performed in childhood, including the genetic testing referred to by the patient, could not be retrieved, and the diagnosis therefore rests on that earlier assessment together with the episode of bleeding through intact skin witnessed during the present admission. A careful examination of the oral cavity and of the nasal fossae during an episode, and endoscopy performed while bleeding is active, would be the logical way to document the mechanism in future observations.

CONCLUSIONS

Hematomidrosis is an exceptional condition whose manifestations are not confined to the skin. In a patient with an established diagnosis, haematemeses should be investigated in the usual way, because a treatable endoscopic lesion must never be missed; but when upper endoscopy is normal or shows only non-specific changes such as erythematous gastritis, the bleeding may reasonably be related to the underlying condition.

Recognising this possibility avoids two symmetrical errors: attributing every bleeding episode to the known disease without excluding a gastroduodenal lesion, and conversely pursuing indefinitely, through repeated and increasingly invasive investigations, a lesion that does not exist. In this rare setting, the diagnostic reasoning of the emergency physician remains the decisive element of management.

Additional Information

Human subjects:

Consent was obtained by all participants in this study. Written informed consent for publication of the clinical data and of the photograph was obtained from the patient. The report has been anonymised: no identifying data and no element allowing recognition of the patient appear in the text or in the image.

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following:

Payment/services info: All authors have declared that no financial support was received from any organisation for the submitted work.

Financial relationships: All authors have declared that they have no financial relationships at present or within the previous three years with any organisations that might have an interest in the submitted work.

Other relationships: All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

Author contributions: All authors participated in the management of the patient, contributed to drafting the manuscript and approved the final version.

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