PERFORATION OF A PEPTIC ULCER WITH MIGRATION OF HEMOSTATIC CLIP: A RARE COMPLICATION IN THE TREATMENT OF UPPER GASTROINTESTINAL HAEMORRHAGE.

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Abstract

Hemostatic clips are one of the most common treatment options for upper gastrointestinal haemorrhage, allowing for monotherapy in Forrest IIa or higher-grade bleeding. Complications associated with them are infrequent, limited to erosions and minor bleeding related to their deployment. We present the case of a patient with upper gastrointestinal haemorrhage secondary to a duodenal peptic ulcer. The patient was treated using a combination of various hemostatic methods, which resulted in perforation of the ulcer and migration of a hemostatic clip into the duodeno-pancreatic groove.

Keywords: hemostatic clip, perforation, upper gastrointestinal haemorrhage.

Introduction

Upper gastrointestinal haemorrhage (UGH) is one of the most frequent digestive pathologies, especially secondary to peptic ulcer. About 30% require endoscopic treatment[1]. The most common are the use of adrenaline for sclerotherapy and mechanical therapy using haemoclips. Serious complications secondary to the use of these methods are rare. Adrenaline may cause tachycardia and hypertension due to its passage into the peripheral blood. Regarding haemostatic clips, with an efficacy of more than 90% in achieving cessation of bleeding, complications are rare, with erosions secondary to their use and intestinal perforation after their release having been described[2]. However, we present the case of a patient with UGH who presented migration of a haemoclip into the duodenopancreatic groove through the perforation of a peptic ulcer, a complication that has not been described to date.

Clinical Case

We present a 69-year-old patient with haematochezia and haemodynamic instability suggestive of rapid transit in the context of an upper gastrointestinal haemorrhage. Laboratory tests showed a decrease of 5 haemoglobin points. An urgent upper gastrointestinal endoscopy was performed and a 23mm ulcer was found in the first superior duodenal flexure, with active drooling bleeding and visible vessel (Forrest IB), which was treated with adrenaline injection, placement of haemoclips, haemostatic clamp and haemospray to control the haemorrhage.

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After 48 hours, the patient began to show signs of gastrointestinal haemorrhage, abdominal pain and haemodynamic instability. An angio-CT scan was requested, which showed perforation of the previously described ulcer and an image of a foreign body in the duodeno-pancreatic groove of about 9 mm, compatible with a migrated haemostatic clip.

After spontaneous cessation of bleeding, the patient remained asymptomatic, allowing conservative management of the perforation, and was finally discharged.

Discussion

Haemostatic clips are a fundamental pillar in the management of UGH and can be used in monotherapy in Forrest IIa and IIb haemorrhages. They are a safe treatment with few complications, although duodenal perforation following their use has been described, but very infrequently. The particularity of this case is the migration of the clip into the duodenopancreatic groove, a complication that has not been described. Management of the perforation will depend on the patient's condition; in case of instability or peritonitis, it will be surgical[3]. In cases where there is no such evidence, conservative initial treatment with close monitoring of the patient may be consid.

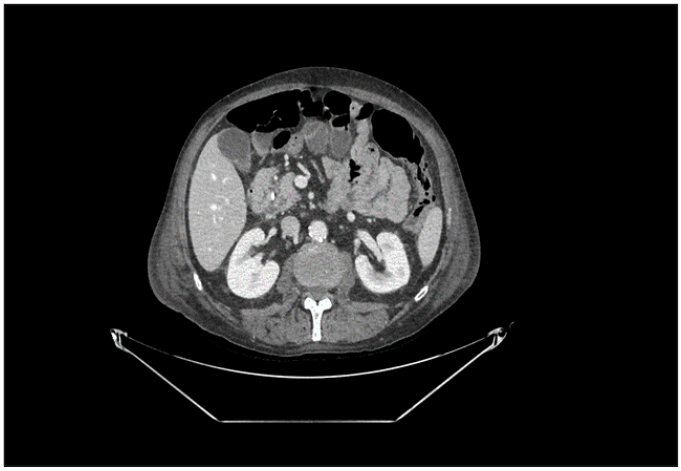

Figure 1. ***In this image we can see the contained perforation and a hyperdense image corresponding to the migrated clip in the duodeno-pancreatic groove.***

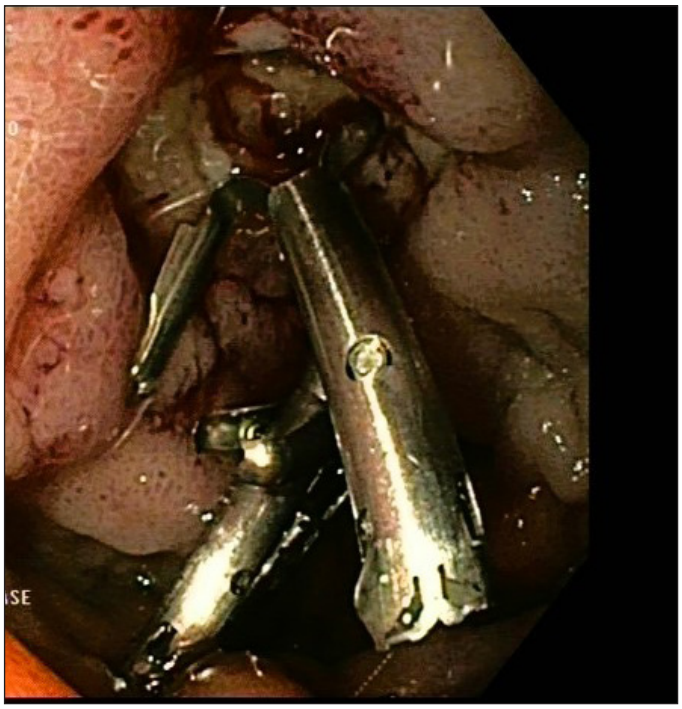

Figure 2. ***Figure corresponding to the upper gastrointestinal endoscopy in which we can see the ulcer after treatment with several clips.***

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