A Rare Manifestation of a Bleeding Tubulovillous Duodenal Polyp Presenting as an Upper Gastrointestinal Hemorrhage

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INTRODUCTION

• Duodenal polyps are a group of polyps that are fairly uncommon to find on endoscopic evaluation (1).
• They are histologically classified according to mucin phenotype into intestinal and gastric subtypes; the intestinal-type polyps are morphologically subdivided into tubular and tubulovillous adenomas (2).
• We present a case of a 76-year-old male with recurrent hematemesis who was found to have an intestinal-type pedunculated Tubulovillous adenoma (TVA) in the descending duodenum.
• An isolated occurrence of non-ampullary sporadic duodenal adenomas (SDA’s) are a rare finding and presentation as an upper GI hemorrhage is extremely uncommon (3).
• Furthermore, Our patient’s polyp was pedunculated which is atypical because most SDA’s are morphologically flat or sessile (4).
• The purpose of this case is to present a rare cause of upper gastrointestinal bleeding and to depict characteristics of an isolated duodenal TVA and its treatment options.

CASE REPORT

History of Present Illness:

• 76-year-old male from a long-term care facility presented for feeling “off” and having increased respiratory secretions.
• He also complained of coughing, wheezing, and dyspnea.

Physical Exam:

• On physical exam, he appeared frail, his abdomen was soft, non-tender, and with normal bowel sounds, he also had marked basilar rhonchi on auscultation of chest.

Hospital Course:

• He was initially placed on bilevel positive airway pressure, however, his mental status continued to decline and he required intubation for acute hypoxic respiratory failure secondary to bacterial pneumonia and a CHF exacerbation, which was treated with IV diuretics and antibiotics.
• Gastroenterology was initially consulted for coffee ground hematemesis with a hemoglobin of 9.9 g/dL (baseline).
• There was no endoscopic intervention done at this time because he was hemodynamically stable.
• His hematemesis was thought to be secondary to apixaban and aspirin for CAD and PAF and thus his apixaban was stopped.
• Gastroenterology was re-consulted when the patient’s hemoglobin decreased to 6.6 g/dL and orogastric lavage revealed 1L of coffee-ground material.
• At that time, the patient underwent an emergent esophagogastroduodenoscopy (EGD) which revealed a 10mm pedunculated polyp in the proximal duodenum with active bleeding (Figures 1-2).
• The polyp was resected with hot snare and clipped twice (Figure 3).

Figures 1-2: 10mm tubulovillous pedunculated polyp in the proximal duodenum with active bleeding

• After EGD, the patient’s hematemesis resolved and his hemoglobin stabilized back to baseline.
• However, his CHF and pneumonia progressed and worsened his respiratory failure, so his family opted for comfort measures and the patient died.

Pathology:

• Biopsy of polyp tissue revealed a tubulovillous adenoma with minute foci of high grade dysplasia.

Figures 4-6: Biopsy of polyp tissue revealed a tubulovillous adenoma with minute foci of high grade dysplasia.

DISCUSSION

• Our patient had a pedunculated, intestinal-type, tubulovillous adenoma, which is a rare phenomenon.
• Non-ampullary sporadic duodenal adenomas are those which arise in patients without a known polyposis syndrome, such as Familial Adenomatous Polyposis or Gardner’s syndrome (4).
• Most patients are asymptomatic and very few present primarily with a upper GI hemorrhage, as seen in this case.
• The risk of carcinoma is greater in ampullary adenomas and increases with the size of adenoma (4).
• EGD techniques that are currently used for treatment include endoscopic snare and electrocautery, which was successful in this case as the patient’s hematemesis resolved.

CONCLUSION

• Duodenal polyps are a rare occurrence and most are , but pedunculated polyps should be resected and biopsied.
• EGD surveillance within 1-6 months is recommended as non ampullary sporadic adenomas have been linked to an increased risk of colorectal neoplasia (4).
• It is also important for practitioners to keep in mind rarer causes of upper GI bleeding.

REFERENCES

5. Hoon FD, Klimstra DS, Hruban RH, Fishman EK. Ampullary adenomas and increases with the size of adenoma (4).
6. EGD techniques that are currently used for treatment include endoscopic snare and electrocautery, which was successful in this case as the patient’s hematemesis resolved.