PHOTO QUIZ

A 45-YEAR-OLD MALE WITH UPPER GASTROINTESTINAL BLEEDING AFTER ALCOHOL ABUSE

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A 45 year-old male with an antecedent of repeated vomiting followed by haematemesis and melena was admitted for diagnosis, investigation and treatment. He related a high daily ingestion of distilled and fermented alcoholic beverages. Physical examination revealed a pale and dehydrated patient, with hypotension and tachycardia. Thoracic and abdominal evaluations were unremarkable. Laboratory determinations showed moderate anaemia, mild elevations of transaminases and alkaline phosphatase, and high levels of gama-glutamyl-transpeptidase. Upper digestive endoscopy disclosed acute mucosal erosions both on the distal oesophagus and at the oesophagus-gastric transition, and bleeding laceration without perforation (Figure 1). A conservative treatment was performed, and a rapid clinical improvement was followed by a good outcome (Figure 2).

What is the most probable diagnosis?

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**Figure 1:** Upper digestive endoscopy image of the acute erosions and longitudinal lacerations (arrows) detected at the oesophagus-gastric transition, with signals of recent bleeding.

**Figure 2:** Images of control endoscopic evaluation (performed 48 hours after the local injection of 1/10,000 epinephrine solution) showing conspicuous improvement of mucosal changes and almost total healing of the oesophageal lacerations (arrows).
ANSWER to PHOTO QUIZ

Mallory-Weiss syndrome (MWS)

MWS is characterized by high upper gastrointestinal haemorrhage secondary to longitudinal lacerations in the cardio-oesophageal junction, without perforation. This entity was first described in 1929, involving patients with repeated vomiting after alcoholic libations. Precipitating factors also include straining at stool, coughing, convulsions, hiccupps, chest massage, abdominal trauma, colonoscopy preparation, and local injury during upper endoscopy. More often, MWS follows a sudden increase in the intragastric/ intrathoracic transmural pressure gradient. The oesophageal bleeding spontaneously ceases in most of the cases, but haemodynamic instability may indicate the need for intensive care assistance and surgery. Options for haemostasis include proton pump inhibitor (PPI), epinephrine, thrombin; thermal probe; laser; electro coagulation; and band ligation. Digestive endoscopy is the first choice procedure to confirm the clinical suspicion of MWS in patients with upper gastrointestinal bleeding (UGIB). UGIB often occurs among elderly people with co morbid conditions, and chronic alcoholism can play a predictive role in the outcome. UGIB may represent a clinical and economic burden on the public health system with 10-14% of mortality. This has remained unchanged among us, as well as in European countries. Etiologic factors of nonvariceal UGIB include peptic ulcers, mucosal erosions, spontaneous perforations, haematoma, angiodysplasia, and Dieulafoy lesions, in addition to MWS. Alcohol abuse predisposes to retching and repeated vomiting, the main precursors of MWS, which is associated with UGIB in up to 15% of the patients. In developing areas, alcohol is usually the drug most consumed, and systemic disturbances due to alcohol excess increase general morbidity, and precocious death rate; therefore, avoiding abuse will reduce its socio-economic impact. In the present case, the origin of MWS was associated with alcohol libation. The suspected diagnosis was supported by clinical data and confirmed by endoscopy study, and bleeding tears were treated with PPI and a local injection of 1/10,000 epinephrine. A second endoscopy, performed 48 hours later, showed significant improvement of mucosal changes and absence of bleeding (Figure 2). The patient was discharged from hospital without complaints, and is under specialized surveillance for the treatment of chronic alcoholism. The aim of our photo-quiz was to raise awareness concerning MWS, a condition with variable outcome, which can affect young and elderly groups, and emphasizes the global adverse role of alcohol abuse.

REFERENCES