



Gastric Intramural Hematoma: A Case Report

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Introduction

Gastric intramural hematoma is an uncommon disorder. It is caused by coagulopathy, trauma, aneurysm, peptic ulcer disease, pancreatitis, endoscopic therapy or spontaneous hematomas [1]. Here, we describe a gastric intramural hematoma which occurred as an unexpected complication of surgically revascularized critically ischemic limb and successfully treated by surgical approach.

Case Summary

An 83-year-old gentleman with Past medical history of this patient was Diabetes-II, Hypertension, ischemic heart disease and old stroke. The patient underwent right femoro-popliteal bypass with debridement due to critical limb ischemia and infected gangrene of the heel. Then shifted to the intensive care unit for close monitoring post operatively. The patient started on aspirin 81 mg, clexane 40 mg, and Plavix 75 mg. While in the intensive care unit on the same day of surgery, the patient hemoglobin dropped from 11.9 g/dl to 6.2 g/dl. Abdominal examination was soft and lax with mild epigastric tenderness. Ultrasound of the abdomen revealed no intra-abdominal free fluid. He was transfused 3 units of packed red blood cells. Hemoglobin became 11.13 g/dl after transfusion. Two days later developed hematemesis, hemoglobin dropped to 8.2 g/dl. The patient became hemodynamically unstable, requiring intubation, inotropic support, intravenous fluids and packed red blood cells. Physical Examination was unremarkable.

Laboratory examinations showed the following: white blood cell count $9.2 \times 10^9/L$, hemoglobin 8.2 g/dL, platelet count $319 \times 10^9/L$, prothrombin time 12.8 s, activated partial thromboplastin time 40.3 s and INR 1.1.

Ultrasonography was normal. An emergency upper endoscopy was performed with no evidence of esophageal or gastric varices was found and .The stomach was full of coffee ground fluid with no active bleeding (Figure 1). The remainder of the stomach and the duodenum was endoscopically normal.

On completion of the upper endoscopy, no diagnosis was confirmed. To be further investigated by a computed tomography (CT) angiogram, but it couldn't be done because the patient's condition was hemodynamically unstable, and he developed abdominal distention and guarding.

Abdominal ultrasound was repeated and revealed massive amount of intra-abdominal free fluid. He underwent emergency laparotomy, we found intra peritoneal collection approximately 2 liters free blood & blood clots.

Stomach cavity full of blood clots and there was an intramural hematoma 15 cm \times 20 cm in the posterior wall of the stomach ruptured through the greater curve and cavity between mucosa & muscularis mucosa (Figure 2).

The hematoma evacuated and the cavity packed with surgical Repair of greater curve done. Mass closure of the abdominal wall with two drains inserted.

Recovery was uneventful, on the next day post op the patient extubated and inotropes discontinued. The patient was allowed oral intake three days after surgery. There was no evidence of gastric leak upon commencing diet, and drains were removed one week later. The patient was well at discharge. At the one-year follow-up, he was well and without complications.

Discussion

Intramural hematoma of the gastrointestinal tract is an uncommon occurrence, with the majority being localized to the esophagus or duodenum [2].

Hematoma of the gastric wall is very rare, and has been described most commonly in association with coagulopathy, peptic ulcer disease, and trauma or idiopathic.

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Figure 1: Gastric endoscopy showing the stomach was full of coffee ground fluid with no active bleeding.

Diagnosis of gastric hematomas

The CT scan is the current diagnostic procedure of choice for gastrointestinal-wall hematomas because it has the ability to precisely differentiate whether a mass is solid or liquid [3].

Ultrasound has poor discriminatory capacity for gastric hematomas, showing an anechoic or hypoechoic pattern that is nonspecific and can mimic gastrointestinal neoplasm or inflammatory lesions.

Management of gastric hematomas

Gastric hematomas secondary to intrinsic coagulopathy are generally managed conservatively. The patient reported in our case study was therapeutically treated with aspirin, clexane and Plavix. The diagnosis not done by CT. The patient treated with surgical approach and he recovered fully with no complication during one year of follow-up [4,5].

We presented this case because of the rarity of the condition as well as the possible association of two etio-pathogenic factors: antiplatelets therapy and mechanical manipulation by endoscopy.



Figure 2: An intramural hematoma 15 cm x 20 cm in the posterior wall of the stomach ruptured through the greater curve and cavity between mucosa & muscularis mucosa.

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