Hemobilia. A case report
Case Report

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Abstract

We present the case of a 88 years old male, with a history of melena, demonstrated by repeated endoscopies to be secondary to hemobilia, and after endoscopic retrograde cholangiopancreatography we could demonstrate the presence of bleeding intraductal cholecocus polyps with histopathological report of intraepitelial adenoma. Hemobilia is a rare cause of upper gastrointestinal hemorrhage with an increasing incidence because of the widespread use of invasive hepatobiliary procedures and improved recognition. In the majority of cases the cause is iatrogenic. The classical presentation of hemobilia is with biliary colic, jaundice, hematemesis, and melena. The diagnosis and evaluation of hemobilia is facilitated by the use of sonography, computed tomography and endoscopic retrograde cholangiopancreatography. Persistent bleeding sometimes requires urgent therapeutic intervention, such as angiography or surgery.

Key words: Adenoma, gastrointestinal hemorrhage, hemobilia, polyps.

Case report

We present the case of a 88 years old male, resident of Nuevo Leon, Mexico. He a medical history of cigarette smoking from the 16 to the 76 years old, and alcohol intake from 16 to 85 years old. Uncomplicated cholecystectomy by acalculous cholecystitis in 1996. In 1997 and 1998 the patient presented melena, requiring hemotransfusion medical treatment with omeprazol. Endoscopic diagnostic was gastritis and esofagitis. In 1999 the endoscopic diagnostic of hemobilia was made. In 2001, he was treated in Monterrey, Nuevo Leon, Mexico for increase in the frequency of melenic evacuations, and severe weakness that disabled him to carry out his normal activities. His symptoms were accompanied with dyspnea. He was referred to National Medical Center “20 de Noviembre”, ISSSTE, Mexico for his treatment.

The physical examination revealed temperature of 36.4°C, the pulse was 80, and the respirations were 18. The blood pressure was 110/60 mmHg. Pale, without neurologic affection, normal cardiac exploration, there was no rebound tenderness or Murphy’s sign, there were no abdominal masses and bowel sounds were normal.

A digital rectal examination was positive to melena. All the laboratory tests were normal, except hemoglobin was 7.5 mg/dL, glucose of 187.6 mg/dL and albumin of 1.7 g/dL. While hospitalized a new gastroscopy showed polyps of the duodenum. The endoscopic retrograde cholangiopancreatography (ERCP) showed, images suggesting intraductal choledocus polyps, as well as dilation of cholecocus and intrahepatic bile ducts, being subjected to surgery exploration observing polyps in the left hepatic duct, taking a biopsy that reported intraepitelial adenoma (Figure 1). His evolution was torpid, presenting data of obstructive jaundice, and manifestations of hepatic encephalopathy that remitted with medical treatment. It is presented as rare case of hemobilia due to intraepitelial adenoma of polyps inside the choledocus.

Discussion

Hemobilia is an uncommon cause of upper gastrointestinal hemorrhage. Its incidence has increased in recent years because of the widespread use of invasive hepatobiliary procedures¹ and improved recognition. The term hemobilia was first used by Sandblom to describe bleeding into the biliary system after a subcapsular liver injury,² but this term is now used to describe bleeding into the biliary system from any cause, although many investigators only consider bleeding lasting longer than 24 hours.³ Mild to moderate hemobilia is defined as bleeding that resolved within 48 hours and do not necessitate transfusion. Severe hemobilia is considered with hemorrhage resulting in hemodynamic instability or necessitating transfusion.

In the majority of cases the cause is trauma, iatrogenic (liver biopsy, percutaneous transhepatic cholangiography), with the mean period to onset of bleeding after accidental hepatic trauma of 4 weeks,¹ infections (typically parasitic), tumors, inflammatory disorders, and gallstones, other caus-
The cause of hemobilia must be corrected. Persistent bleeding sometimes requires urgent therapeutic intervention, such as angiography or surgery. In cases of hemorrhagic cholecystitis, surgery is obviously curative. In case of hemobilia during transhepatic biliary drainage treatment begins with assessment of catheter position. Fistulous communication of the biliary tree with a portal or hepatic vein branch can usually be managed by upsizing the drainage catheter with resultant tamponade of the bleeding site.

Hemobilia from a hepatic artery source frequently requires transcatheter embolization via a right femoral artery approach or even hepatic artery ligation, which can result in liver failure in patients with underlying hepatic insufficiency. Angiography may provide an opportunity for arterial embolization which can be a simple, safe, and effective treatment for hemobilia with less morbidity and mortality than surgery.

References

2. Sandblom P. Hemorrhage into the biliary tract following trauma—“traumatic hemobilia”. Surgery 1948; 24: 571-586.