When Uncommon Turns Severe: Massive Gastrointestinal Bleeding in Gastric Hyperplastic Polyps

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Clinical Course:

A 58-year-old woman with a medical history of alcohol use disorder presented with hematemesis. She was admitted to the intensive care unit (ICU) after she was found to have a hemoglobin level of 3 gm/dl and an INR of 1.7. She required a transfusion of 5 units of Packed Red Blood Cells (PRBCs) and 1 unit of Fresh Frozen Plasma (FFP. Urgent esophagogastroduodenoscopy (EGD) showed two 25-35 mm multi-lobulated polyps with stigmata of recent bleeding at the gastroesophageal junction. Histopathology was consistent with hyperplastic polyps (Figure 1-2). Polyp resection was deferred to be done by the advanced endoscopy team. She was treated for alcoholic hepatitis and acute kidney injury on the medical floor and several days later, she had sudden-onset bouts of hematemesis resulting in hemorrhagic shock requiring transfer back to the ICU. Repeat EGD showed two 25-35 mm pedunculated bleeding polyps at the gastroesophageal junction. Bleeding was controlled by epinephrine, and hemostatic clips were placed along each polyp's stalk. She had ongoing bleeding after EGD, thus left gastric artery embolization was performed by interventional radiology. After the procedure, she remained hypotensive with worsening acute kidney injury. As a result, she required continuous renal replacement therapy, vasopressor support, and prolonged ICU. Unfortunately, she passed away within the next few days due to multiorgan failure.

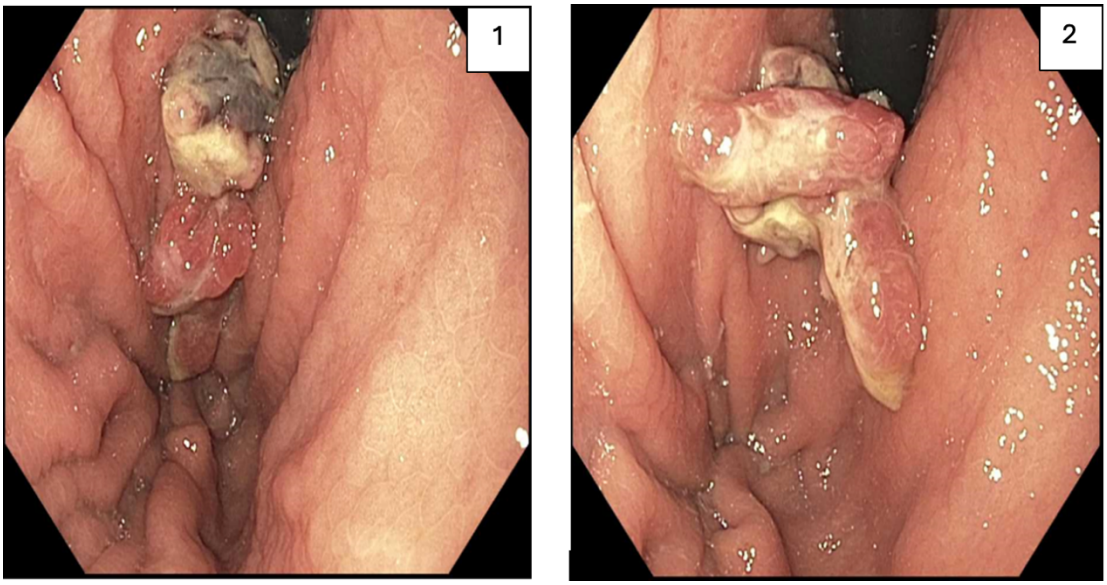

Figure 1-2: Two multilobulated hyperplastic polyps at the gastroesophageal junction (GEJ) with stigmata of recent bleeding in Figure 1.

Take away:

Gastric hyperplastic polyps are among the most common gastric polyps[1-3]. They are more common in older individuals and are usually asymptomatic. Other times, they present with anemia due to chronic blood loss. This article highlights the uncommon occurrence of massive GI bleeding in these polyps. The management of our patient was further complicated by alcoholic hepatitis resulting in encephalopathy, coagulopathy, and hepatorenal syndrome. Interestingly, our patient did not have esophageal varices, the presumed source of massive GI bleeding in similar patients.

References:

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