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Cecal Angiodysplasia in Adults

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Abstract **Case Report**

Digestive angiodysplasias are better known since the development of angiography and endoscopy. Their cause is poorly understood. Most are probably acquired and the consequence of age-related degenerative lesions. Bleeding linked to digestive angiodysplasia is often treated successfully by endoscopy or less frequently by hormonal therapy, the effectiveness of which is debated. Surgical resection has shown its effectiveness in significant hemorrhages.

Keywords: Angiodysplasia, digestive vascular malformation, digestive hemorrhage.

INTRODUCTION

Vascular malformations of the digestive tract were first mentioned in the literature in 1839; and it was in 1974 that the term intestinal angiodysplasia (AI) was defined as a superficial acquired vascular lesion, single or multiple, developed in the mucosa and/or submucosa of the wall of the digestive tract, without being associated to a cutaneous or visceral angiomatous lesion [1, 2]. Different equivalent terms may be encountered in the literature: "arteriovenous malformation", "telangiectasia", "vascular ectasia".

OBSERVATION

Patient aged 39, without specific ATCDS, followed in the gastroenterology department since 2015 for recurrent colonic angiodysplasia lesions with a negative etiological assessment (cases no aortic stenosis or Willebrand disease, renal failure). Revealed by recurrent melena abdominal CT angiography revealing cecal angiodysplasia supplied by the caeco-appendicular artery Figure (1 and 2). Therapeutically, the patient benefited from 7 sessions of argon plasma coagulation, the last of which revealed, on endoscopic exploration, the presence in the cecum of several angiodysplasia lesions with signs of active bleeding.

The surgical decision was taken after the failure of endoscopic treatment (persistence of bleeding and the appearance of pneumoperitoneum). Surgical exploration was carried out using a conventional approach which did not reveal any hollow organ perforation, thinned appearance of the cecal wall and ascending colic without other associated anomalies. The procedure was a right hemicolectomy with end-to-end anastomosis.

The anatomo-pathological study of the part shows cecal angiodysplasia, the ileal and colonic resection limits are healthy.

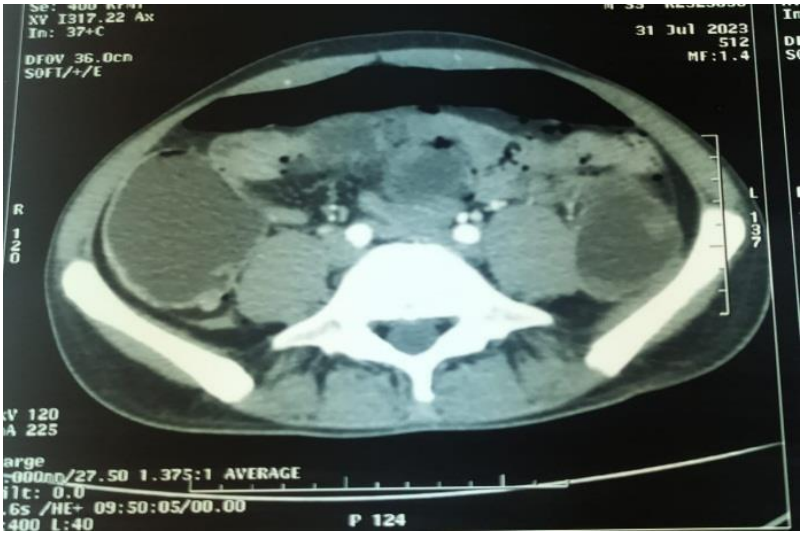

Figure 1: Discreet thickening of the external wall of the cecum with dilation of the coeco-appendicular artery

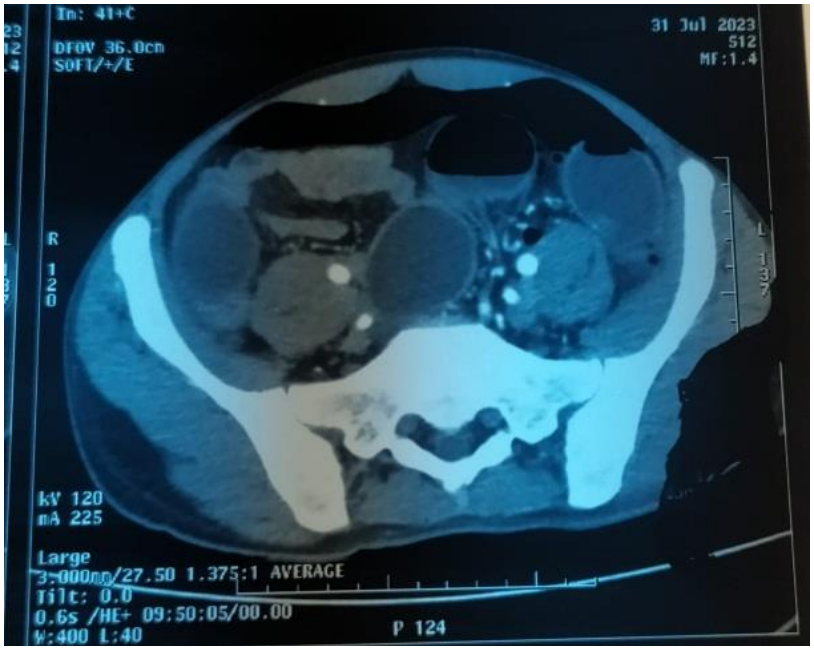

Figure 2: Significant pneumoperitoneum associated with discreet peritoneal effusion

DISCUSSION

Angiodysplasia is located in 80% of cases in the right colon and the cecum, in 15% of cases in the small intestine in the literature. Gastrointestinal bleeding is frequently observed in patients suffering from cardiovascular complications such as aortic stenosis.[3]and patients followed for Willebrand disease [4, 5], renal failure [6] in our case no aortic stenosis or Willebrand disease, renal failure.The investigations depend closely on the clinical presentation and the severity of the digestive bleeding.The development of endoscopy techniques and the quality of the video endoscopes used, particularly in terms of image resolution, make endoscopy the first avenue to follow for diagnosis. CT angiography and MRI angiography are two techniques that make it possible to diagnose digestive bleeding in a non-invasive way but without therapeutic possibility and with a theoretical risk of radiation for the scanner when it is repeated. In a recent study of 26 patients with hemorrhagic IA of the colon, the sensitivity, specificity and positive predictive value were 70%, 100% and 100%, respectively [7]. Our patient underwent abdominal CT angiography revealing pneumoperitoneum with discreet peritoneal effusion with cecal angiodysplasia supplied by the ceco-appendicular artery. The rate of rebleeding after treatment with CPA (argon plasma coagulation) is between 7 and 15% with a median follow-up of 6 to 20 months [9, 10]. The complication rate ranges from 1.7% to 7%. Perforation is a rare (< 0.5%) but serious complication. The indications for surgical treatment of hemorrhagic IAs have become exceptional due to major advances in digestive endoscopy and interventional radiology. Surgery may be proposed when the following conditions are met: acute and significant digestive

bleeding, the source of which has been clearly identified, requiring a blood transfusion and after failure of non-invasive endoscopic and radiological techniques. Intraoperative endoscopy can help localize the source of acute bleeding or chronic bleeding; after failure of all other strategies [8], our patient underwent right hemi colectomy with end-to-end ileocolic anastomosis terminal.

CONCLUSION

Intestinal angiodysplasia is the most common vascular malformation of the digestive tract. Diagnosis and treatment are essentially based on endoscopic techniques. However, the management strategy for the hemorrhagic form must also take into account drug treatments, interventional radiology techniques and, more rarely, surgical techniques.

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