Sir,

Intestinal diverticulosis refers to sac like protrusions at the points of intestinal wall weakness where the blood vessels are penetrating. They are mostly asymptomatic but they can present in the form of pain, perforation, hemorrhage or combination of these. Intestinal vessels responsible for diverticulosis, curl over the wall of diverticula, and are separated from the lumen only with the mucosa. These vessels get weak and rupture into the lumen after continuous trauma. We report a case with different disease combination and treatment limitation.

A 52-year gentleman had recurrent admissions for melena and marked drop in Hemoglobin (Hb) up to 3 g/dl. Rest of the blood counts and biochemical parameters were normal. Stool for occult blood was positive. On upper Gastrointestinal (GI) endoscopy, there was fissuring, scalloping and reduction of duodenal mucosal folds height. Histopathology of duodenal mucosa showed infiltrations of intraepithelial lymphocytes, crypt hyperplasia and increased villus crypt ratio (Marsh 3 type). His anti-Tissue Trans Glutaminase (anti-TTG) IgA and IgG antibodies were positive. These findings were suggestive of coeliac disease. He was advised gluten-free diet but there was no response despite clear instructions. Subsequent investigations including colonoscopy, Computerized Tomography (CT) of abdomen with intravenous and oral contrast, CT angiography and RBC labelled scintigraphy scan during the bleeding episodes were normal. On double balloon push enteroscopy, large complex diverticulae seen starting from proximal jejunum till end of ileum, most likely source of bleed. He had poor dietary compliance as evident by raised anti-TTG antibodies levels on follow-up, dietary counselling reinforced but showed no improvement in Hb. His reason for marked anemia was GI bleed secondary to small intestinal diverticulosis as he had recurrent melena and associated sudden drop in Hb. Patient did not respond to hormonal therapy, i.e. combination of estradiol or progesterone.

Endoscopic, angiography with embolization and surgical resection are recommended in case of uncontrolled bleed, failure of interventional treatment and recurrent severe diverticular bleeding. Treatment fixations are that neither angiographic embolization is possible because of wide spread disease and poor localization of the bleeder, nor resection of all the small bowels as it will end up with short bowel syndrome, that is an even worse situation. On the other hand, he may have transfusion related problems as well. Small bowel transplantation is indicated in short bowel syndrome; mostly the cause is Crohn’s disease, mesenteric ischemia, trauma and surgical complications. Intestinal transplantation may be an option in this extensive dual pathology with certain limitations like need for specialized centre and expert transplant team. Pre-conditioning of the recipient with lymphocyte reduction, followed by use of immuno-suppression-based single-agent like tacrolimus. The 1-year survival is now over 90% in most US centers.

REFERENCES