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Hemobilia: A Rare Case of Upper Gastrointestinal Bleed

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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Case Study

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ABSTRACT

Hemobilia is a rare but important cause of upper gastrointestinal haemorrhage that refers to bleeding from and/or into the biliary tract. Hepatic artery aneurysmal rupture is one of cause for the hemobilia. The common visceral aneurysm with the highest reported rate of rupture is Hepatic Artery Aneurysm (HAA). Depending on the size of the aneurysm, clinical manifestations include epigastric pain, biliary tract obstruction, gastrointestinal (GI) bleed, aneurysm rupture and death. HAA is a rare disease with an incidence of 0.002%–0.4% of which 50 % is hepatic pseudo aneurysm. In this case report ,we discussed a case of 55years female with complains of abdominal pain for 15days , yellowish discolouration of skin and sclera for 15days and multiple episodes of hematemesis with Malena for 2 days.

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1. INTRODUCTION

Hemobilia is bleeding into the biliary tree. It is a rare cause of upper GI bleed. Most of the Hemobilia cases are iatrogenic and caused by invasive procedures involving liver, pancreas, bile duct, hepatopancreaticobiliary vasculature [1]. Non iatrogenic causes of hemobilia include gallbladder and bile duct stones, biliary varices, biliary parasite infestation like *Ascaris lumbricoides,* benign and malignant tumors of biliary tree, liver surgery (including transplantation), congenital or acquired vascular aneurysms, pancreatitis, and hepatitis (drug-induced or autoimmune).

2. CASE PRESENTATION

Here I am reporting an interesting Case of 55 years old female patient presented to emergency department with complains of abdominal pain for 15 days, which was acute in onset and intermittent in nature. She also complains of jaundice for 15 days and had multiple episodes of hematemesis in last 2 days leading to anaemia, tachycardia, hypotension, significant drop in haemoglobin (Hb) . Previously patient underwent Cholecystectomy for calculus cholecystitis, followed by ERCP stenting on 12th post operative day for common hepatic duct stricture (benign biliary stricture) with cholangitis & obstructive jaundice. On physical examination, Patient was conscious, oriented, irritable & had pulse 123/Min, BP was 80/60 mm of Hg & respiratory rate was 24 breaths/Min. Patient had severe pallor and jaundice. Laboratory investigations revealed Hb of 6.2gm/dl, alkaline phosphatase 412 IU/L with total bilirubin 17.4 mg/dl. Patient resuscitated with 3 Packed cell volume and 4 fresh frozen plasma transfusion.

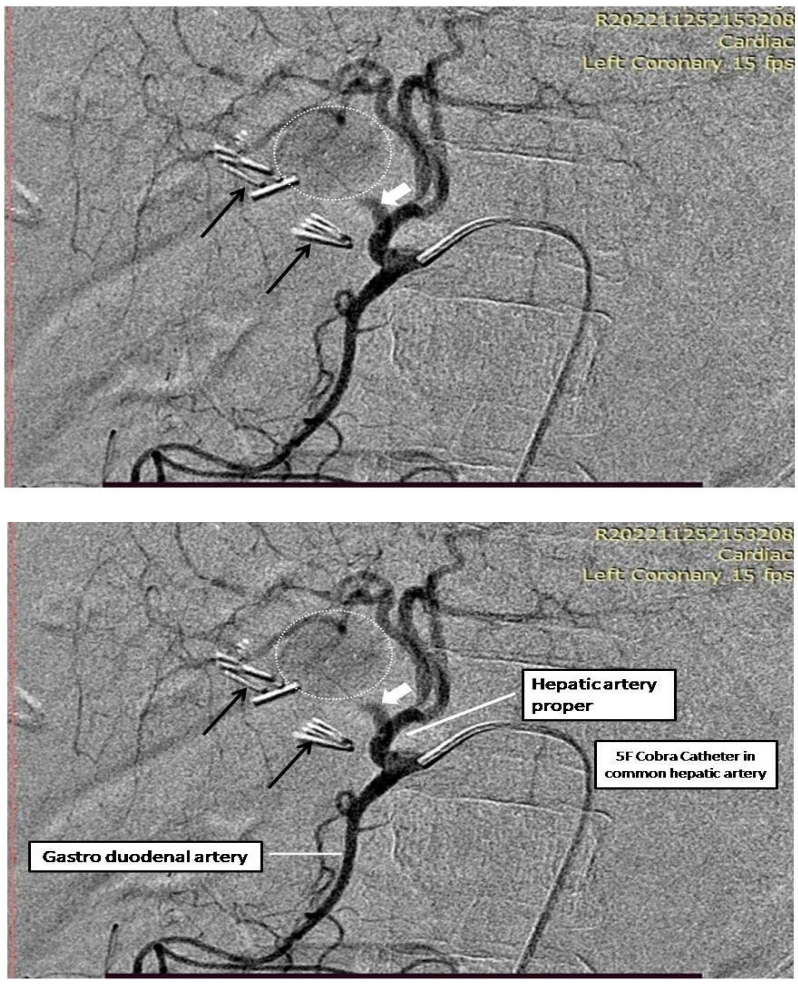

Fig. (1) & (2). Pseudoaneurysm at common hepatic artery

Triple phase CT abdominal angiography showed rupture of common hepatic artery Pseudo aneurysm with dilated hepatic and common bile duct with haemobilia and obstructive jaundice as its sequelae. Patient was managed successfully with common hepatic artery pseudo aneurysm angio embolisation with multiple platinum micro-coils by interventional radiologist.The haematemesis and Malena was controlled and patient became vitally stable.

3. DISCUSSION

The first case report of haemobilia was from Francis Glisson in 1654[2]. Antonie portal was the first person to publish a case of haemobilia identified antemortem. Most common cause of haemobilia is iatrogenic trauma during surgical intervention procedure like laproscopic or open Cholecystectomy or rarely ERCP or in traumatic injuries. Rupture of common hepatic artery Pseudo aneurysm is also reported as a source of bleeding [3-5]. Hemobilia presents like melena, or substantial upper gastrointestinal bleeding [6-7], which causes hemodynamic instability in the patient. A patient with haemobilia may have acute biliary pain due to bile duct distension and obstruction. Primary resuscitation of patient to be done with intravenous fluids, blood transfusion, fresh frozen plasma (FFP) transfusion and

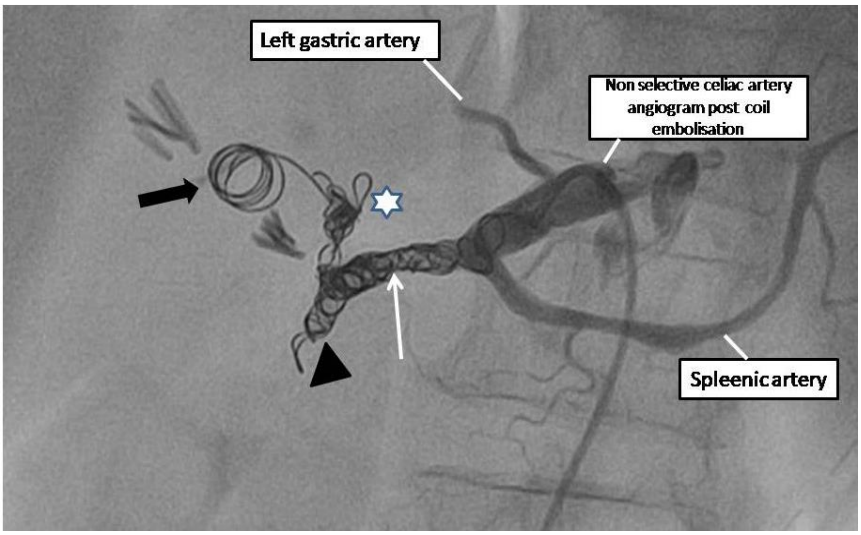

Fig. 3. Embolisation and coiling of common hepatic artery

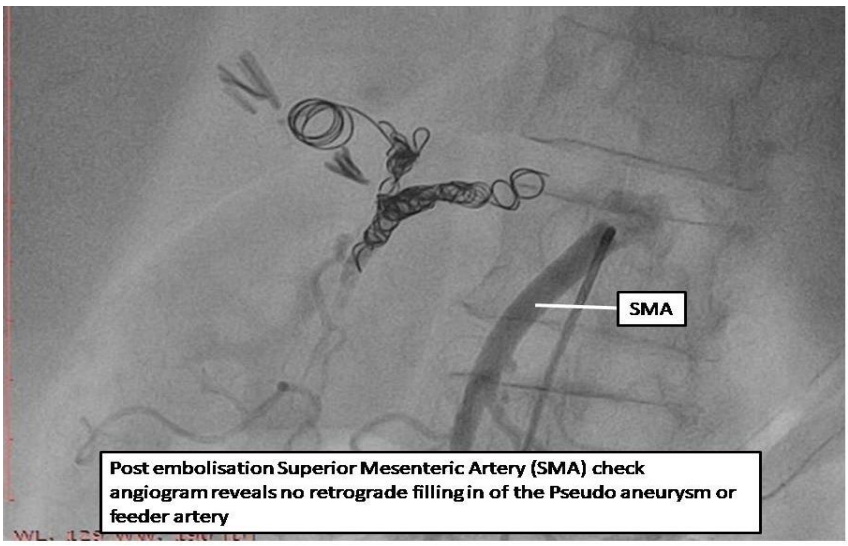

Fig. 4. POST Embolisation Superior mesentric artery check angiogram reveals no retrograde filling in the pseudoaneurysm or feeder artery

inotropic support. There are mainly two definitive therapeutic options for this emergency clinical scenario. Such emergencies can be managed by surgical gastroenterology with ligation of bleeding vessel or interventional radiology with endo vascular angio embolisation. The present case was resuscitated successfully and after haemodynamic stability, patient was subjected for endovascular angio embolization which Post operative course was uneventful and patient was discharged on 4th postoperative day and under follow up for 3 months.

4. CONCLUSION

The haemobilia is very rare cause of G.I bleeding. Such rare cause should be suspected when there is history of any surgical intervention or trauma to liver or biliary system. With the new advent of G.I surgery and interventional radiology, Such cases are diagnosed in the time and treated successfully with the help of interventional radiology procedures like endovascular coiling or plugging [8-10].

CONSENT

As per international standards or university standards, patient(s) written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standards or university standards written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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