HHT and gastric telangiectasia

A 58-year-old Taiwanese married male presented to our emergency department with progressive dizziness and generalized weakness for 1 week. His blood pressure was 138/91 mmHg and heart rate was 74 bpm. He stated that nosebleeds occurred off and on for more than 20 years, and he had been diagnosed pulmonary arteriovenous malformation (AVM) and received coils embolization in April, 2009 (Figure 1a). He also received coronary artery bypass graft surgery due to coronary artery disease before. Besides, his mother, elder brother and son suffered from intermittent nosebleeds for a long time, and his son had the history of pulmonary AVM and received coils embolization before. There was no evidence of stroke or infectious disease for the patient. Routine laboratory tests revealed microcytic anemia with a hemoglobin level of 6.9 g/dL. There was positive finding in stool occult blood test. Esophagogastroduodenoscopy (EGD) and colonoscopy demonstrated telangiectases in stomach (Figure 1b) and colon, and endoscopic argon plasma coagulation therapy was performed for these lesions. Blood transfusion with packed red blood cells was also prescribed for his anemia.

Hereditary Hemorrhagic Telangiectasia (HHT), also known as Rendu-Osler-Weber disease, is a rare autosomal dominant vascular disease. The vascular malformations are arteriovenous shunts termed telangiectases (if small) or AVMs (if large).1 Clinical diagnosis of HHT is made when a person presents three of the following four criteria: family history, recurrent nosebleeds, mucocutaneous telangiectasis, and AVM in the brain, lung, liver and gastrointestinal (GI) tract.2 Epistaxis and skin telangiectasis are the most common presenting symptoms that appear in over 90% of HHT patients aged over 60 years.3 Most elderly HHT patients suffer from anemia due to epistaxis and GI bleeding. When a patient presented with anemia and gastric telangiectases in endoscopic examinations, careful history taking, including family history is crucial. Further studies to confirm the existence of AVM of brain, lung and liver are necessary if suspicion of HHT.

Photographs and text from: P.-L. Lay, Division of Gastroenterology, Department of Internal Medicine, Kaohsiung Armed Forces General Hospital, Kaohsiung, No. 2, Zhongzheng 1st. Rd., Lingya District, Kaohsiung City 802, Taiwan and Division of Gastroenterology, Department of Internal Medicine, Tri-Service General Hospital, No. 325, Sec 2, Cheng-Gong Rd., Neihu, Taipei 114, Taiwan; T.-Y. Huang and C.-H. Hsu, Division of Gastroenterology, Department of Internal Medicine, Tri-Service General Hospital, No. 325, Sec 2, Cheng-Gong Rd., Neihu, Taipei 114, Taiwan. email: ndmchsu@yahoo.com.tw

Conflict of interest. None declared.

References