

# Unusual Causes of Upper Gastrointestinal Bleeding



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## KEYWORDS

- Cameron lesions • Dieulafoy lesions • Gastric antral vascular ectasia
- Duodenal varices • Hemusuccus pancreaticus • Hemobilia • Ampullary carcinoma
- Aortoenteric fistula

## KEY POINTS

- Upper gastrointestinal (GI) bleeding is a commonly encountered clinical condition managed by endoscopists, and appropriate diagnosis and treatment require the ability to recognize both common and uncommon causes of bleeding.
- Knowledge of unusual causes of upper GI bleeding will help increase clinical suspicion and allow for prompt diagnoses when these uncommon causes are encountered.
- Certain unusual causes of upper GI bleeding require multidisciplinary management, including endoscopists, surgeons, and interventional radiologists.

## CAMERON LESIONS

Initially described by Philemon Truesdale in 1924<sup>1</sup> and then further expanded on in a case series published by Cameron in 1976,<sup>2</sup> Cameron lesions are best described as linear erosions or ulcerations found at the distal end of a hiatus hernia sac in close proximity to the diaphragmatic pinch (**Fig. 1**). The prevalence of these lesions has been estimated to be between 3% and 5% in the presence of any hiatal hernia and is directly related to the size of the hernia. In patients with large hiatal hernias (>5 cm), the prevalence has been reported to be greater than 12%.<sup>3,4</sup> Interestingly, a recent study from 2013 found a prevalence of 0.2% in patients hospitalized for overt upper gastrointestinal (GI) bleeding and 3.8% in patients hospitalized for obscure causes of GI bleeding (**Table 1**).<sup>5</sup> The mechanism for the formation of Cameron lesions is not clearly defined. Many experts thought they occur in patients with hiatal hernias as a result of mechanical trauma and local ischemia caused by repetitive movement of the hernia sac against the diaphragm. Histologically, the changes to the normal mucosa are consistent with ischemia, and biopsy of these lesions can often be

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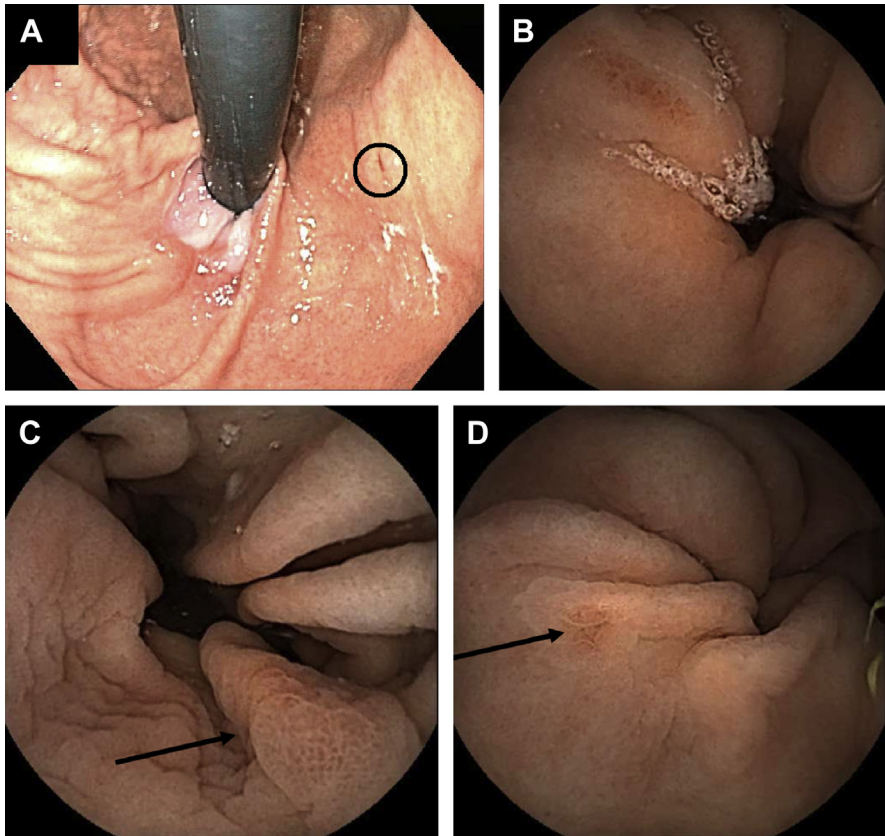
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**Fig. 1.** Cameron lesions. (A) Retroflexed view during upper endoscopy showing a singular Cameron erosion with a black circle. (B–D) Cameron lesions as seen on capsule endoscopy denoted by the black arrows in 1C and 1D.

confused for ischemic gastritis.<sup>6</sup> Alternatively, there have been some reports in the literature noting that Cameron lesions can result from acid reflux, ischemia, *Helicobacter pylori* infection, gastric stasis, or vascular stasis.<sup>7</sup> It is likely that these lesions occur from multiple causes, including possible underlying genetic mutations, medical comorbidities, and medications.

Cameron lesions are often a source for both overt and obscure GI bleeding. They can present as frank hematemesis, melena, or iron deficiency anemia. The hernia neck and sac should be meticulously evaluated during esophagogastroduodenoscopy (EGD) and specifically in retroflexed views as small Cameron lesions can often be difficult to visualize. In addition, it is important for the endoscopist to gauge whether

Table 1 Prevalence of Cameron lesions in various clinical scenarios	
With any hiatal hernia	3%–5%
With hiatal hernia >5 cm in size	12%
Any overt upper GI bleeding	0.2%
Obscure GI bleeding	3.8%

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