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Overlooked complication of anticoagulant therapy: The intramural small bowel hematoma—A case report

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ABSTRACT

INTRODUCTION: Intramural small bowel hematoma is a rare, and often overlooked consequence of anticoagulant therapy. In this report we present such a case in order to bring forth awareness to this entity, and its management.
PRESENTATION OF CASE: We report a 81-year old male who presented with abdominal pain for 2 days. He had been under anticoagulant therapy with warfarin for 9 years, presenting with an elevated INR of 6,2. Intramural small bowel hematoma was confirmed with abdominal ultrasound and CT scan. The patient was treated conservatively with anticoagulant suspension and administration of antidote, and was subsequently discharged after 6 days.
DISCUSSION: Abdominal complaints and an elevated INR value point to the possible diagnosis of intramural small bowel hematoma, however these abdominal symptoms can vary between a mild pain and an established acute abdomen. CT scan showing symmetric bowel thickening associated with some luminal narrowing confirms the diagnosis. In terms of management, there are not sufficient papers to support a standardized treatment; currently the most accepted approach seems to be conservative treatment after the exclusion of complications that would call for surgery.
CONCLUSION: Anticoagulant therapy is becoming a widespread prescription as the population ages, and intramural small bowel hematoma is one consequence in need of consideration

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1. Introduction

The present work has been reported in line with the SCARE criteria [1].

Anticoagulant therapy is widely used in various clinical situations. However, it brings forth serious complications. The incidence of all bleeding complications during anticoagulant therapy ranges from 5 to 48%, but gastrointestinal haemorrhage occurs in only 2–4% of patients [2].

The only incidence estimation for intramural small intestine hematoma present in the literature was made by Bettler et al. [3] in 1983, based on a retrospective epidemiological survey, and puts it at 1 case per 2500 anticoagulated patients per year.

Keeping this entity in mind is a basic requirement for its diagnosis. According to the largest case series available in the literature, the most common symptom is abdominal pain, followed by emesis [4,5]. Therefore, it is accepted that any patient with a history of use of anticoagulant therapy and prolonged International Normalized Ratio (INR) suffering from abdominal pain should raise suspicion for intramural small bowel hematoma [6,7].

Anticoagulant-induced intramural small-bowel hematoma prevalence is expected to increase, and awareness for this entity is needed. The authors report a case of nontraumatic small intestine intramural hematoma presenting as a complication of anticoagulant therapy.

2. Presentation of case

An 81-year-old caucasian male was referred to the General Surgery Emergency Department presenting with pain in the lower quadrants of the abdomen for 2 days. The patient had been under anticoagulant therapy with warfarin 5 mg id for 9 years because of atrial fibrillation, but he had stopped it 5 days prior to admission because of an elevated INR.

He had a history of two stroke episodes, type 2 Diabetes, COPD, AHT, SOA, and he had a pacemaker. His other medications were directed to his chronic illnesses. There was no record of any genetic or hereditary conditions, or family predispositions.

The patient reported no traumatic incidents, no change in bowel habits or vomiting. He did recall red urine on occasion and a propensity to bruise easily. He presented with a high blood pressure of

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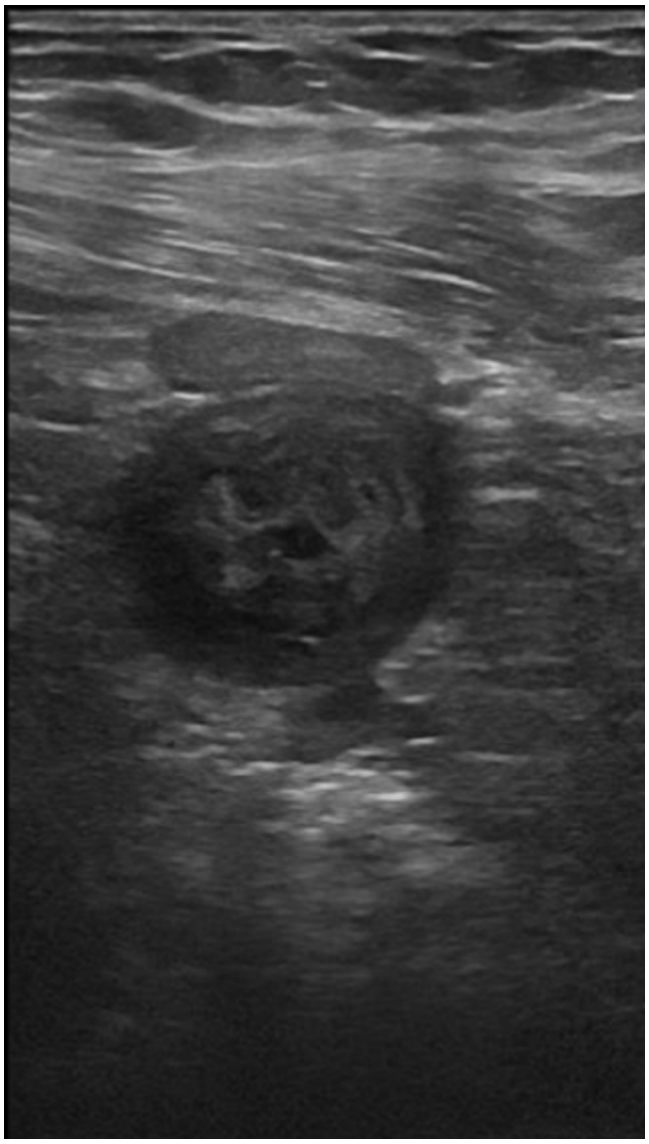

Fig. 1. Abdominal ultrasound showing the transversal view of the thickened small bowel.

177/58 mmHg. Physical examination revealed a tender abdomen over the inferior quadrants; no masses or hernias were evident.

Laboratory data revealed a haemoglobin value of 13,2 g/dL with an activated partial thromboplastin time of 83 s, a prothrombin time of 68,6 s and an INR of 6,2. Other data was unremarkable. Prothrombin complex was initiated and a normal INR was obtained (INR 1,9).

Abdominal ultrasound showed a thickened small bowel loop wall surrounded by fluid (Fig. 1). The CT scan revealed, in the hypogastrum and right iliac fossa, a small bowel loop with thickened walls and adjacent engorged vessels and fat (Figs. 2 and 3).

The patient was admitted to the General Surgery Department for conservative treatment, including nil by mouth, endovenous hydration and pain management. Patient and family showed some reluctance in trusting the proposed treatment, reconsidering when improvement in symptoms was evident.

Having had a favourable and uneventful hospital stay, he was discharged 6 days later without the need for surgery. The imunohemotherapist consulted recommending a switch in anticoagulant therapy to Rivaroxaban 20 mg id.

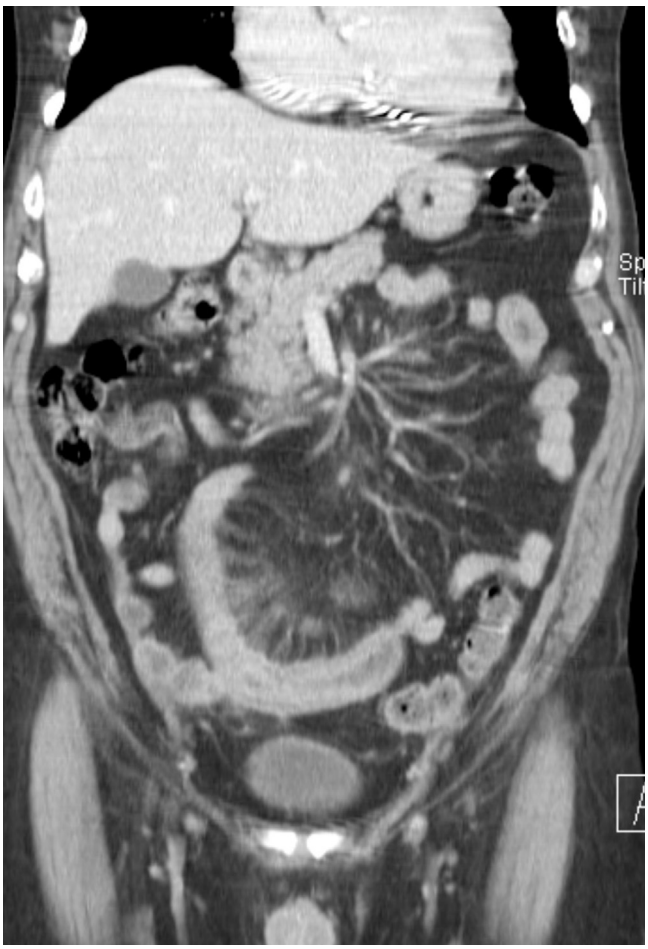

Fig. 2. Coronal view of the abdomen on CT showing thickened small bowel wall and engorged mesentery.

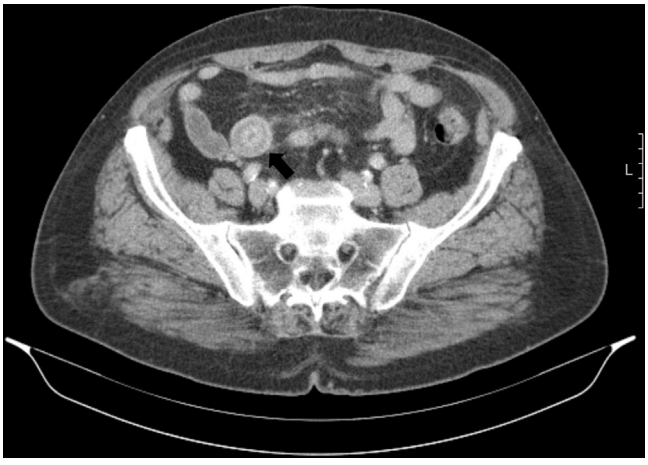

Fig. 3. Transverse view of the abdomen with arrow pointing symmetric bowel thickening, with high attenuation in its acute phase, associated with some luminal narrowing.

Follow-up at approximately 1 month revealed no symptoms and an unremarkable CT (Fig. 4). At 6 months, the patient reported no abdominal complaints.

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