Grace Elta and Robert J. Fontana, Section Editors

An Unusual Cause of Upper GI Bleeding

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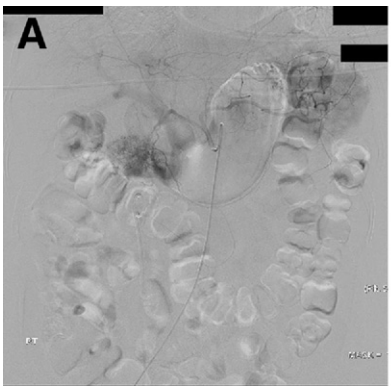

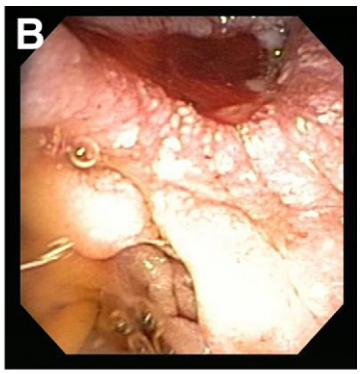

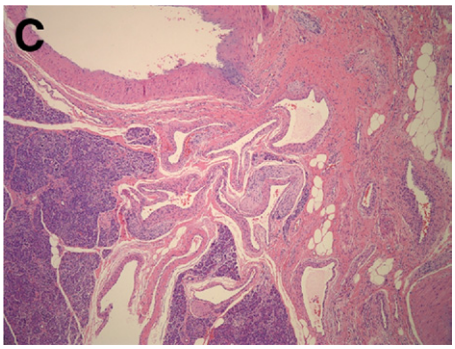

Question: A 47-year-old woman was transferred from an outside hospital with a diagnosis of subarachnoid hemorrhage. She underwent successful coil embolization of a ruptured right anterior choroidal artery aneurysm. Three days later, and while in the intensive care unit, she developed severe hematochezia. She had no abdominal pain, nausea, or vomiting. On physical examination, her blood pressure was 80/40, with a heart rate of 120. Her abdomen was nontender to palpation. Her hemoglobin level was 7.4 g/dL, down from a baseline of 10.4 g/dL. Her platelets, coagulation profile, and liver chemistries were unremarkable.

The patient received multiple units of blood and was stabilized. An esophagogastroduodenoscopy was negative. Colonoscopy revealed large amount of blood and clots, and the procedure could not be completed secondary to poor visualization. Celiac angiography revealed a markedly enhancing lesion within the right upper quadrant (Figure *A*). Embolization of the lesion was unsuccessful. The esophagogastroduodenoscopy was repeated with a side viewing duodenoscope, revealing a deep, 2-cm ulcer in the junction between the first and second part of the duodenum (Figure *B*). The patient continued to bleed and underwent surgical exploration. Pathologic examination of the lesion is shown in Figure *C*. The patient did well postoperatively and is currently doing well >6 months later.

What is the diagnosis?

Look on page 403 for the answer and see the GASTROENTEROLOGY web site (www.gastrojournal.org) for more information on submitting your favorite image to Clinical Challenges and Images in GI.

Conflicts of interest: **The authors disclose no conflicts.**

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Megacolon From Chagas Disease in an Ancient Texan

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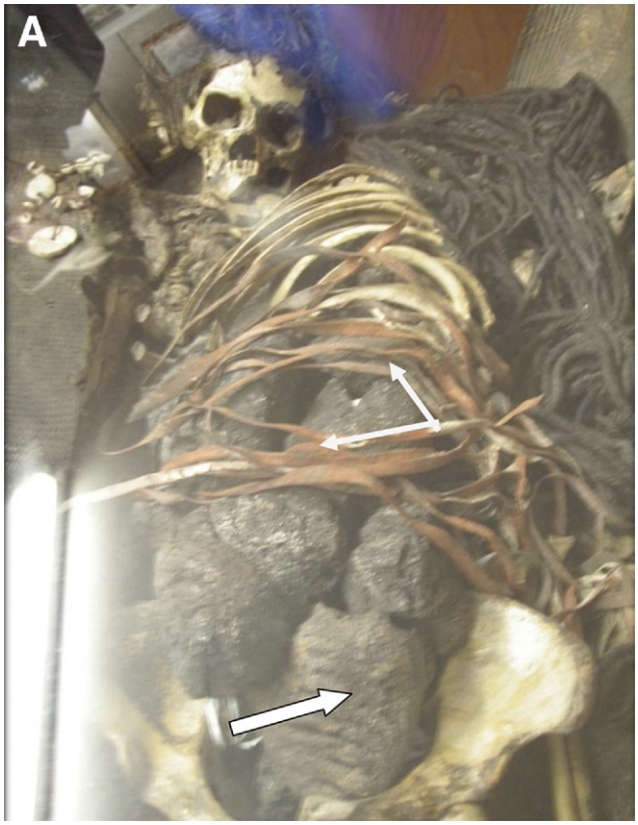
Question: The 1200-year-old remains of a Native American man were found buried in a rock shelter of the Lower Pecos region of south Texas. Death was approximately at 35–45 years of age. The dried, mummified remains contained a massively distended abdomen with deer hide binders encircling his abdomen (*small arrows*) placed during life to presumably support the massive abdominal dilation (Figure *A*). Chewed ingested gastric contents indicated a hunter–gatherer existence that contained vegetable material, insect parts, rodent, and snake skeletal remains. His massively dilated colon (*large arrow*) contained compacted and partially digested food. The remains revealed that the colon filled the entire pelvic cavity and compressed against the spine; the anterior iliac crests left impressions on part of the colon.

What is your diagnosis?



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Recurrent Abdominal Pain in a 55-Year-Old Woman

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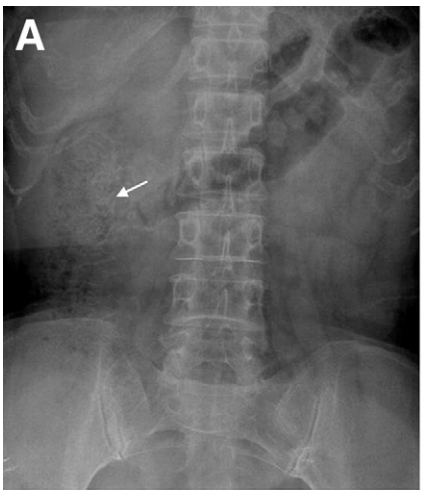

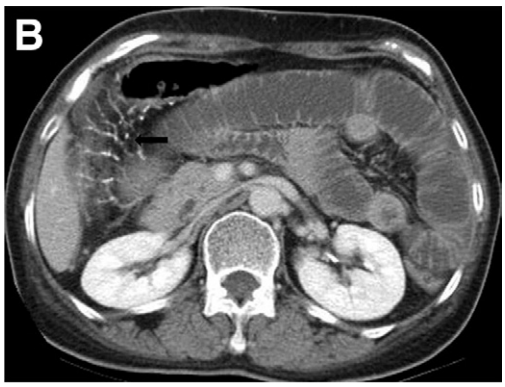

Question: A 55-year-old woman presented with 1-day history of acute diffuse abdominal pain and vomiting. In the past year, she had similar episodes. She also mentioned small-caliber stools and weight loss (10 kg) within the past year. Two days before admission, she had complained of no stool passage. She denied fever, diarrhea, and bloody stool. She had no significant medical history or previous operations. Physical examination revealed a distended abdomen, hypoactive bowel sounds, and diffuse tympanic sound on percussion. Laboratory data revealed unremarkable except mild leukocytosis. Abdominal plain film showed linear calcifications along the right side of the abdomen (Figure *A*). Abdominal computed tomography revealed wall thickening and diffuse, thread-like