Dear Editor,

We present the case of a 71-year-old male with a medical history of hypertension, dyslipidemia, and acute myocardial infarction in 2007 who was taking low-dose aspirin and bemiparin 3500 IU every 24 hours. He was admitted to the Urology Service with recurrent hematuria 14 days after radical prostatectomy, which ceased after continuous bladder irrigation.

During admission, he developed lower gastrointestinal bleeding with hemodynamic instability (blood pressure, 80/40; heart rate, 93 bpm), and blood tests showed hemoglobin at 5.4 g/dL, with normal platelets and INR. An urgent gastroscopy was performed without pathological findings. Colonoscopy showed a colonic angiodysplasia in the cecum, which was treated with argon beam and the placement of 2 hemoclips.

However, the patient continued with daily episodes of hematochezia and frequent blood transfusions. A second colonoscopy was performed identifying a visible clot above the angiodysplasia, which was treated with adrenaline injections and the placement of 5 hemoclips (Fig. 1A). Given the persistence of bleeding, a third
colonoscopy, two CT angiographs, a small-bowel capsule endoscopy, and a selective mesenteric arteriogram were performed, with no signs of active bleeding. After arteriography, the patient presented pulsatile radial bleeding from the catheterization area, and a new episode of hematuria.

In this context, a progressive prolongation of activated partial thromboplastin time (aPTT) levels was observed throughout admission (Fig. 1B). Therefore, the coagulation study was extended, showing factor VIII deficiency with high levels of factor VIII inhibitor, which confirmed the diagnosis of acquired hemophilia A (AHA). Immunosuppressive treatment was started with good tolerance and bleeding cessation.

DISCUSSION
Acquired hemophilia A is a rare disease resulting from autoantibodies (inhibitors) against endogenous factor VIII. The most common manifestation in AHA is subcutaneous bleeding (> 80 %), followed by gastrointestinal bleeding (> 20 %), and then muscle and genitourinary bleeding (1).

There are few cases in the literature about AHA presenting with gastrointestinal bleeding (2-5), and most were idiopathic. Our patient had a history of prostate adenocarcinoma. However, radical prostatectomy was performed, with complete tumor resection, and thus we considered that the etiology was idiopathic in this case.

AHA is a rare cause of gastrointestinal bleeding. Therefore, prompt diagnosis and treatment are critical due to the high risk of mortality. Consequently, AHA should be considered in all patients with a recent onset of abnormal bleeding, an isolated prolongation in activated partial thromboplastin time (aPTT), and normal prothrombin time (PT).

REFERENCES


Fig. 1. A) Angiodysplasia in the cecum treated with adrenaline injections and placement of 5 hemoclips. B) Progressive prolongation of activated partial thromboplastin time (aPTT) levels throughout admission.