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A rare cause of lower gastrointestinal bleeding: acquired hemophilia A

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Dear Editor,

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

During admission, he presented lower gastrointestinal bleeding with hemodynamic inestability (blood pressure 80/40, heart rate 93 bpm), with blood test showing hemoglobin 5,4 g/dL, with normal platelets and INR. Urgent gastroscopy was performed without pathological findings. Colonoscopy showed a colonic angiodysplasia in cecum, which was treated with argon beam and placement of 2 hemoclips.

However, the patient continued with daily episodes of hematochezia, and frequent blood transfusions. A second colonoscopy was performed showing a visible clot above the angiodysplasia, which was treated with adrenaline injection and placement of 5 hemoclips (figure 1A). Given the persistence of bleeding, a third colonoscopy, two CT angiographies, a small bowel endoscopic capsule and a selective mesenteric

arteriography were performed, without signs of active bleeding. After the arteriography, the patient presented pulsatile radial bleeding from the catheterization area, and a new episode of hematuria.

In this context, we observed progressive prolongation of activated partial thromboplastin time (aPTT) levels throughout admission (figure 1B). Therefore, the coagulation study was extended, showing a factor VIII deficiency with high levels of factor VIII inhibitor, which confirmed the diagnosis of acquired hemophilia A (AHA). Inmunosupressive 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%); muscle and genitourinary bleeding[1].

There are few cases in literature of AHA presenting with gastrointestinal bleeding2–5, most of them were idiopathic. Our patient had a history of prostate adenocarcinoma, however, radical prostatectomy was performed, with complete tumour resection; therefore we consider that the etiology in this case is idiopathic.

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

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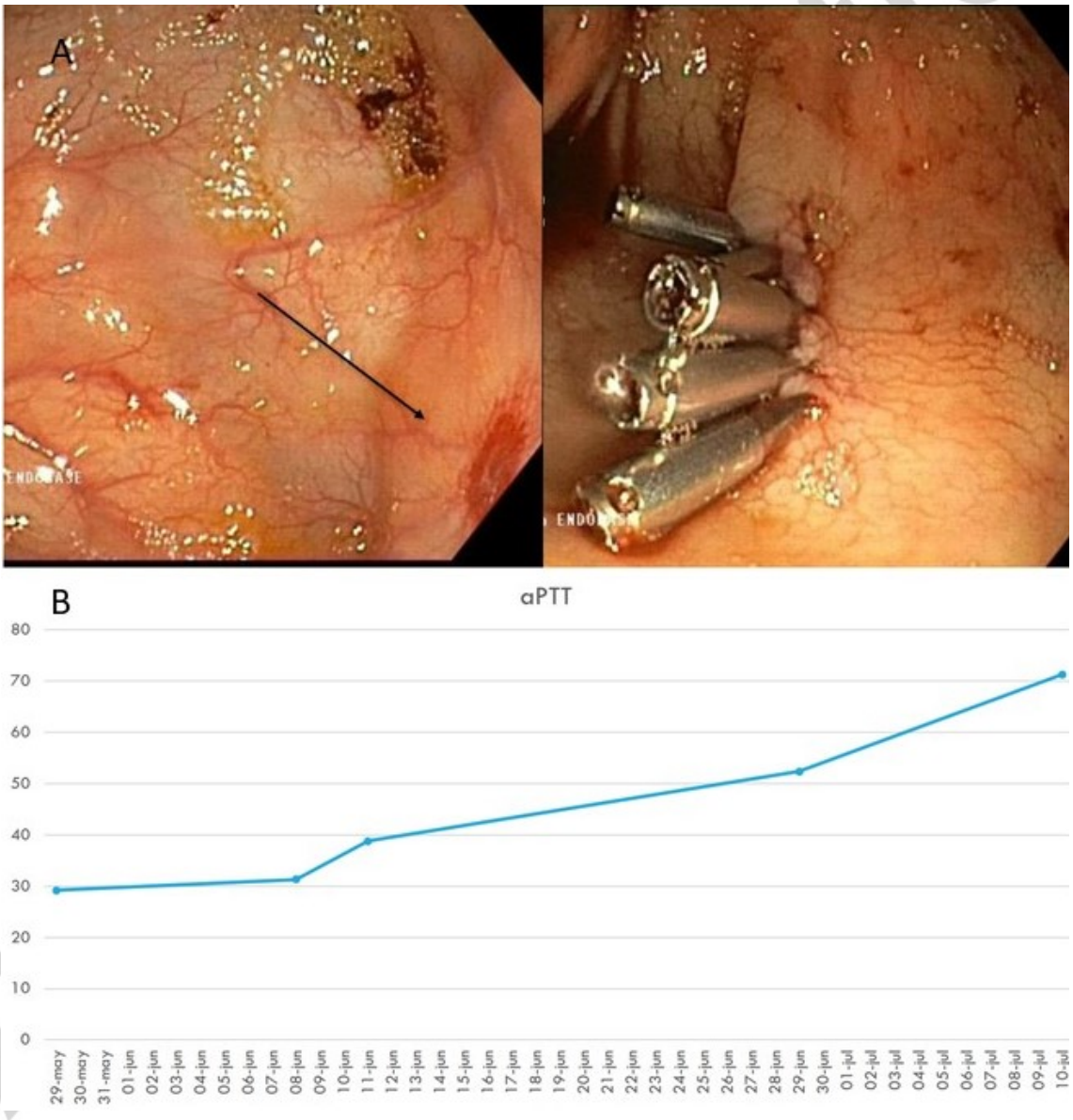

Figure 1: A: angiodysplasia in cecum, treated with adrenaline injection and placement of 5 hemoclips. B: Progressive prolongation of activated partial thromboplastin time

(aPTT) levels throughout admission.