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Case Report
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Blood in Stomach- Is Not Always Haematemesis

Parveen Malhotra*, Yogesh Sanwariya, Vinod Tafe, Senti, Harman Singh and Sandeep Kumar

Department of Medical Gastroenterology, PGIMS, India

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***Corresponding author:** Parveen Malhotra, Department of Medical Gastroenterology, PGIMS, Rohtak, Haryana, India

Abstract

We report a case of thirty fourty eight-year-old male, a chronic smoker for last twenty years and not a known case of any chronic illness, presented with blood in vomitus for one day. He was admitted in some private hospital where after initial stabilization he was subjected to upper gastro-intestinal endoscopy which revealed a mass like lesion at fundus of stomach and suspicion of bleed from it. The concerned endoscopist deferred biopsy at that point of time due to fear of unexpected torrential bleed due to biopsy and planned after few days, once current episode of haematemesis has settled. The relatives on being not satisfied by the approach got patient discharged from that hospital and reported to government set up where repeat endoscopy was done which was found to be absolutely normal. There was a gap of four days between these two endoscopies. At this point of time, he reported to our department for consultation. On re-evaluation, he gave history of blood coming with cough and sputum, thus patient was subjected to contrast enhanced computed tomography scan which showed bilateral basal bronchiectasis. Hence, it proved that haemoptysis was being wrongly interpreted as haematemesis.

Keywords: Haemoptysis; Haematemesis; Endoscopy; Bronchiectasis; Malena

Introduction

Haemoptysis is the expectoration of blood from the tracheobronchial tree which originates from bronchial arteries and is commonly caused by bronchiectasis, chronic bronchitis, and lung cancer. Whenever haemoptysis occurs, it should be confirmed by good history taking, clinical examination, latera l& AP chest X-ray, although a normal chest X-ray does not rule out the possibility of malignancy or other underlying pathology. The role of multidetector computed tomography (MDCT) comes in cases of patients with frank haemoptysis, blood in sputum, suspicion of bronchiectasis or risk factors for lung cancer, and in those with signs of pathology on chest X-ray. Haemoptysis is sometimes misdiagnosed as hematemesis because the symptoms can be similar. Haematemesis is blood in vomitus which has origin from gastro-intestinal tract. Sometimes, patient of haemoptysis gulps their blood in stomach which later on is vomited and the same is wrongly interpreted as haematemesis. The blood from haemoptysis is usually bright red or rust, while in hematemesis it is usually dark red or brown. Blood from haemoptysis may be mixed with sputum and frothy, while blood from hematemesis may be mixed with food particles. Bleeding from hematemesis is usually preceded by vomiting or retching whereas haemoptysis is associated with respiratory symptoms like cough or breathlessness. There are case reports in literature where hemoptysis has been wrongly interpreted as hematemesis [1] leading to multiple non-indicated endoscopies. Thus, a baseline good history is corner stone for differentiating hemoptysis from hematemesis [2], the confusion for the same has been reported in many other case reports [3].

Case Report

We report a case of thirty fourty eight-year-old male, a chronic smoker for last twenty years and not a known case of any chronic illness, presented with blood in vomitus for one day. He was admitted in some private hospital where his baseline complete hemogram showed haemoglobin of 13 gm% with normal total leucocyte count & platelet counts were normal. The INR, bleeding time, clotting time, liver function & renal function test, thyroid profile, blood sugar, ultrasonogram abdomen, chest x-ray and electrocardiogram were essentially normal. He was haemodynamically stable with normotensive readings of blood pressure, pulse and respiratory rates were also normal. He was subjected to upper gastro-intestinal endoscopy which revealed a mass like lesion at fundus of stomach and suspicion of bleed from it. The concerned endoscopist deferred biopsy at that point of

time due to fear of unexpected torrential bleed due to biopsy and planned after few days, once current episode of haematemesis has settled. The relatives on being not satisfied by the approach got patient discharged from that hospital and reported to government set up where repeat endoscopy was done which was found to be absolutely normal. There was a gap of four days between these two endoscopies. At this point of time, he reported to our department for consultation. On re-evaluation, he gave history of blood coming with cough and sputum, thus patient was subjected to contrast enhanced computed tomography scan which showed bilateral basal bronchiectasis. Hence, it proved that haemoptysis was being wrongly interpreted as haematemesis (Figure 1).

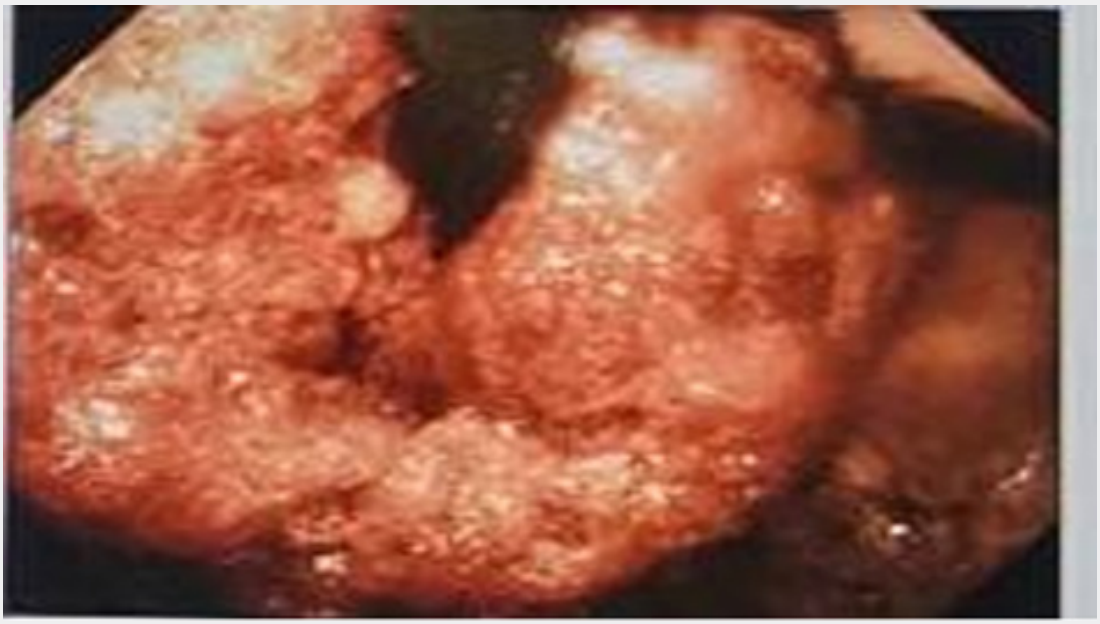

Figure 1: First Endoscopy showing Organized blood which was interpreted as mass lesion.

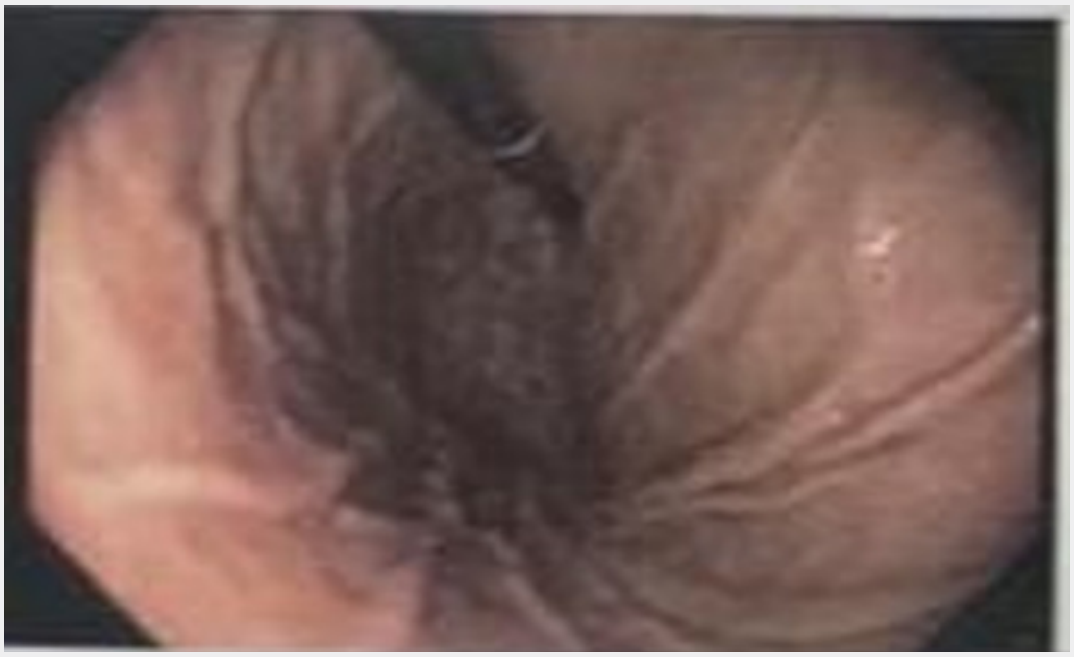

Figure 2: Second Endoscopy showing normal findings at Fundus of Stomach.

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Discussion

The differentiation between haemoptysis and haematemesis is taught at undergraduate as well as post graduate level in medical colleges all over world. The straightforward clinical cases are easily differentiated but sometimes atypical presentations can lead to diagnostic dilemmas. Hence a detailed history taking with proper interpretation of clinical symptoms and investigations can make the proper diagnosis. The clinching point of differentiation between haemoptysis and haematemesis in our case which were missed by first endoscopist was missing of haemoptysis on history and absence of Malena. Moreover, all the biochemical parameters were absolutely normal which can never occur in suspected malignancy of stomach because with such a big lesion in stomach, there will be prolonged history of cachexia, anorexia, weight loss, dysphagia with decreased haemoglobin and serum protein levels. Even, if at endoscopy, proper flushing or probing by forceps would have been done, then it could have been easily proved that it was organized blood clot and not mass lesion at stomach. Later on, the repeat endoscopy ruled out any mass lesion and CECT scan chest confirmed the presence of bilateral bronchiectasis which can be easily missed or not detected on chest x-ray. Hence a proper and clear diagnosis of bronchiectasis was made, and patient was put on regular follow up of respiratory medicine department, as no further gastroenterological intervention was required (Figure 2).

Conclusion

Our case report re stresses the need of proper history taking and right interpretation of clinical symptoms and labs to reach a proper diagnosis which can allay unwarranted fears in treating team, patient and family members. As it is said that everything which glitters is not gold and on same lines it can be well said that every blood in stomach is not haematemesis.

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