CASE REPORT

자발적으로 소실된 특발성 후복막 혈종 1예

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Idiopathic Retroperitoneal Hematoma with Spontaneous Resolution

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A 54-year-old man was transferred from another hospital due to a hematoma in the third portion of the duodenum on abdomen CT. He had been admitted for 2 weeks due to vomiting at another hospital. He had abdominal discomfort and nausea without abdominal pain when he visited the Gwangyang Sarang Hospital. Other than a distended abdomen and mild general abdominal tenderness, the results of physical examination were unremarkable. Abdominal CT revealed an approximately 9 cm thick walled hematoma at the anteroinferior site of the duodenal third portion. Upper endoscopy revealed stenosis of the third portion of the duodenum without mucosal lesions. The endoscope was not advanced through the narrowed duodenal lumen. A retroperitoneal hematoma was diagnosed, and his state was classified as subacute rather than acute based on the duration. The surgeon did not recommend surgical treatment. Urgent treatment was unnecessary; he was managed conservatively. The size of the hematoma decreased from 9.0 cm to 5.8 cm on the following CT. He could begin to eat food on the 26th admission day, and he was discharged on the 31st admission day. The hematoma disappeared entirely on the following CT. This paper describes a rare case of idiopathic retroperitoneal hematoma with a spontaneous resolution. (*Korean J Gastroenterol* 2021;78:295-299)

Key Words: Retroperitoneal space; Hematoma

INTRODUCTION

Retroperitoneal bleeding in the retroperitoneal space is difficult to diagnose, but it can be classified into two retroperitoneal hemorrhage types: acute and chronic type.¹ The acute type requires urgent medical treatment. Acute flank or abdominal pain, low blood pressure, and anemia are the typical clinical findings of retroperitoneal bleeding.^{2,5} On the other hand, the chronic type is stable and may not be lethal. The treatment of the chronic type has not been established.⁶

CASE REPORT

A 54-year-old man visited the other hospital due to vomiting. Despite being admitted for 2 weeks without eating at that hospital, he had had nausea and abdominal discomfort. He was transferred to the Gwangyang Sarang Hospital after abdomen CT. He did not have a history of anticoagulant medication, abdominal trauma, and specific disease. He was a white-collar worker, who drank three bottles of beer per week and was a 30 pack-year smoker. He did not perform strenuous exercise.

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He presented with nausea but did not have vomiting or abdominal pain. His abdomen was distended, but soft and mild general abdominal tenderness was recognized on the physical examination. The mass was not palpable in his abdomen. His general condition remained good, with stable vital signs. The laboratory examinations revealed the following: a white blood count of $8,700/\text{mm}^3$; a hemoglobin level of 15.1 g/dL ; an aPTT and PT (INR) of 35.1 sec and 1.04, respectively (reference range 28-46 sec and 0.85-1.20, respectively); and a BUN and

serum creatinine values of 17.8 mg/dL and 1.31 mg/dL , respectively. The tumor markers, such as CA 19-9 and CEA, were within the normal level. Abdominal CT showed an approximately 9.0 cm thick walled hematoma at the anteroinferior site of the duodenal third portion extending to the right anterior perirenal fascia (Fig. 1). Upper endoscopy was performed on day 1. Despite not eating for several days at the other hospital, there was a significant amount of retained fluid on the upper endoscopy (Fig. 2). Upper endoscopy showed a narrowed duode-

Fig. 1. Abdominal computed tomography demonstrated an approximately 9 cm thick walled hematoma (arrows).

Fig. 2. Upper endoscopy showed narrowed duodenal lumen and a significant amount of retained fluid.

nal lumen by compression (Fig. 2). The endoscope was not advanced through the narrowed duodenal lumen. The patient was diagnosed with a retroperitoneal hematoma, and surgical treatment was discussed with a surgeon. The surgeon recommended medical treatment because his state was stable. He was managed with nasogastric tube suction and bowel rest. The follow-up laboratory exams on the 4th admission day showed a white blood count of $7,700/\text{mm}^3$ and a hemoglobin of 15.3 g/dL. The surgeon was consulted every week, but the surgeon continually recommended medical treatment. His symptoms, such as nausea and abdominal discomfort, were improving. On the 20th admission day, an upper gastrointestinal series showed dilatation of the duodenal bulb with barium passage disturbance to the jejunum (Fig. 3). From the 22nd admission day, he could drink water. On the 24th admission day, abdominal CT demonstrated an approximately 5.8 cm

thick walled hematoma at the anteroinferior site of the duodenal third portion. He could eat on the 26th admission day. He was discharged without complications on the 31st admission day. After discharge, follow-up abdominal CT revealed no evidence of residual retroperitoneal hematoma and no adjacent duodenal wall thickening (Fig. 4). The site of bleeding could not be found in the patient. Vessel malformations, such as arteriovenous malformation, arteriovenous shunt, or aneurysm, were not found. The patient was diagnosed with idiopathic retroperitoneal hematoma. Follow-up upper endoscopy showed patent duodenal lumen without compression (Fig. 5). The cause of the bleeding in this case was unclear. He did not undergo surgery and recovered fully without complications.

Fig. 3. Upper gastrointestinal series showed passage disturbance at the duodenal second-third portion (arrows).

Fig. 4. Abdominal computed tomography showed no evidence of residual retroperitoneal hematoma and no adjacent duodenal wall thickening.

Fig. 5. Follow up upper endoscopy showed the patent duodenal lumen without compression.

DISCUSSION

Retroperitoneal bleeding is rare and is often difficult to diagnose because of the nonspecific symptoms. Most retroperitoneal bleeding is associated with diseases, such as a tumor, trauma, thrombotic thrombocytopenic purpura, hematologic disease, or Evans syndrome.⁷ Other than these existing diseases, anticoagulants are one of the reported risk factors for spontaneous retroperitoneal bleeding.⁸⁻¹⁰ The patient did not have any medical diseases or medications mentioned above. The clinical findings vary according to the amount of bleeding (sudden or gradual). The site of bleeding and surrounding structures are also important. The treatment strategy for retroperitoneal hematoma is decided by the hemodynamics and the cause of the hemorrhage. There are two types of clinical manifestations determined by the radiological findings, such as MRI.¹¹ Three types are also classified by the duration: the acute stage is less than 7 days after onset; the subacute stage is 7 days to 7 weeks after onset; the chronic stage typically begins 7 weeks after onset.¹ The acute type can be lethal. Urgent management is important because the bleeding can cause hemoperitoneum in the acute type. The patient was admitted to the Gwangyang Sarang Hospital after 2 weeks of admission at another hospital and did not have clinical findings of the acute stage. The hematoma was

believed to be subacute by the duration and clinical symptoms. Medical treatment rather than surgical treatment was selected after consultation with the surgeon. There was no hematoma expansion after admission, and the patient's general condition was well with stable vital signs. The patient was discharged without operation or tube drainage. Delayed stenosis of the duodenum did not occur.

The patient returned to the hospital 2 years later after discharge. The patient lived well without any problems. This paper reports a case of idiopathic retroperitoneal hematoma. Although the duration of admission was too long, the hematoma resolved spontaneously. Physicians should always consider the clinical signs and symptoms, including CT and MRI, and then decide on better treatment.

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