

Sclerotherapy with ethanolamine oleate is an acceptable approach for treating esophageal varices, peptic ulcer disease, and Dieulafoy's lesions. Most of the reported complications associated with ethanolamine oleate have been anecdotal and include portal/mesenteric vein thrombosis [1], hepatotoxicity [2], acute renal failure [3], purulent meningitis [4], noncardiogenic pulmonary edema [5], spinal cord paralysis, and disseminated intravascular coagulation. We report here a patient with a Dieulafoy's lesion in whom treatment with ethanolamine oleate injection was complicated by splenic infarction. To the best of our knowledge, no similar cases have previously been reported. This report should alert endoscopists to the potential risks of ethanolamine oleate injection in the treatment of bleeding vessels.

A 59-year-old man presented to the emergency room with melena and hematemesis. Hematocrit was 39.5%. Endoscopy revealed a small hiatal hernia with a bleeding vessel on the hiatal margin. Epinephrine and alcohol were injected. The patient later developed an episode of syncope. His hematocrit dropped to 31%. He vomited blood, and an urgent second gastroscopy was carried out, in which the same bleeding vessel with a clot on it was observed. The impression was of a Dieulafoy's lesion. Two Hemoclips were placed initially at the bleeding site, but the bleeding continued, and 2 ml of 5% ethanolamine oleate solution was injected. The bleeding stopped immediately. Two hours later, the patient developed fever and severe abdominal pain, requiring narcotics. An emergency computed tomography showed a thickened gastric wall at the site of the injection, compatible with hematoma, and low-density areas in the spleen with a fluid collection, compatible with splenic infarction (Figure 1). Fine-needle aspiration of the splenic collection revealed a sterile, bloody fluid. Clinical improvement was noted after conservative management, but marked asymptomatic thrombocytosis of $1.2 \times 10^6/\text{ml}$ de-

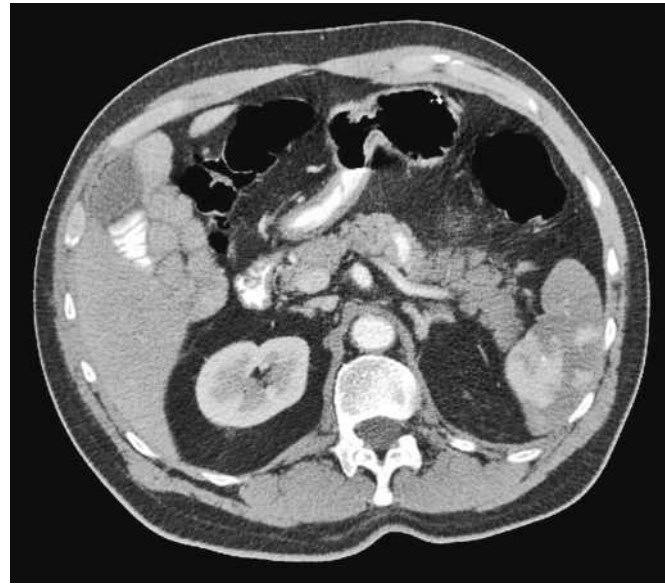


Figure 1 Abdominal computed tomography with intravenous and oral contrast, showing peripheral low-density areas in the spleen, compatible with splenic infarction. Low density and edema are also visible in the tail of the pancreas.

veloped. The patient was discharged with an antiplatelet aggregation treatment.

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