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Asma Nazneen Palagiri, Osmania Medical College
Falak Hamo, Al Andalus University for Medical Sciences
Salih Samo, Emory University
Saurabh Chawla, Emory University

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Coil Erosion Into the Duodenum Following Arterial Embolization

Asma Nazneen Palagiri, MBBS\(^1\), Falak Hamo, MD\(^2\), Salih Samo, MD, MSc, FACP\(^3\), and Saurabh Chawla, MD, FACG\(^3\)

\(^1\)Osmania Medical College, Hyderabad, Telangana, India
\(^2\)Al Andalus University for Medical Sciences, Al-Qadmus, Syria
\(^3\)Division of Digestive Diseases, Emory University School of Medicine, Atlanta, GA

CASE REPORT

A 44-year-old woman presented with hematemesis and melena. Laboratory evaluation showed a hemoglobin of 3.6 g/dL, down from 9.7 g/dL 1 month prior. An esophagogastroduodenoscopy revealed a large nonbleeding ulcer with a visible vessel in the duodenal bulb (Figure 1). Cauterization of the vessel was complicated by profuse bleeding and attempts to achieve hemostasis with epinephrine injection, electrocauterization, and clip placement failed. The patient subsequently underwent angiogram, which did not reveal any active extravasation. However, empiric coil embolization of gastroduodenal, inferior pancreaticoduodenal, and right gastroepiploic arteries was performed successfully (Figure 2). Repeat esophagogastroduodenoscopy 3 days later for continued melena showed the large duodenal ulcer with the embolization coils eroding through the ulcer bed into the duodenal lumen (Figure 3).

**Figure 1.** Esophagogastroduodenoscopy revealing a large nonbleeding ulcer with a visible vessel in the duodenal bulb.

**Figure 2.** Successful coil embolization of gastroduodenal, inferior pancreaticoduodenal, and right gastroepiploic arteries.
The incidence of coil migration has been reported up to 3%.\(^1\) Coil migration may occur early after the embolization procedure if the base of the duodenal ulcer is eroding into the vessel or much later due to a local inflammatory response incited by the coil. No intervention is usually required for local migration due to the fibrosis around the migrated coil, although occasionally distant migration, ulceration, or rebleeding may occur.\(^2\)–\(^4\) Distal migration of embolization coils is rare, and these patients are usually asymptomatic; hence, prophylactic removal of these coils is not advised. For symptomatic patients, given that no consensus has been established, each case should be individually addressed in a multidisciplinary fashion in collaboration with interventional radiology and surgery. Our patient was discharged 10 days after the initial presentation in stable condition. The patient remained stable on clinic visits at 2 weeks and 3 months after discharge with no evidence of gastrointestinal bleeding.

DISCLOSURES

Author contributions: AN Palagiri and S. Samo wrote the manuscript. All authors reviewed and approved the manuscript. S. Samo is the article guarantor.

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