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INDONESIAN DIGESTIVE DISEASE WEEK (IDDW) 2018

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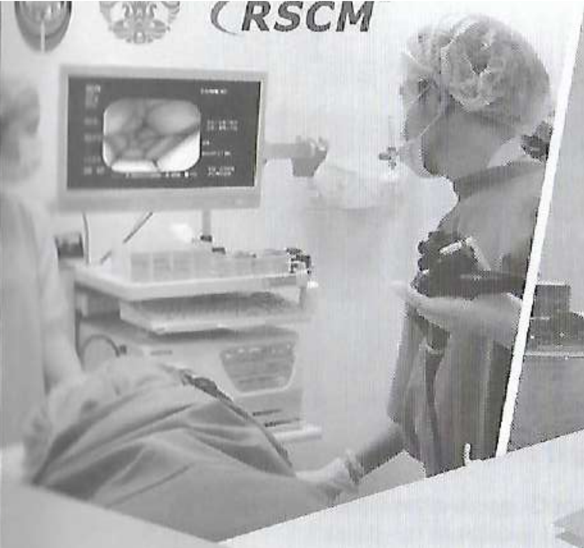

dr. Kaka Renaldi, SpPD-KGEH

INDONESIAN DIGESTIVE DISEASE WEEK (IDDW) 2018

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Hasan Maulahela
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PROCEEDING BOOK
INDONESIAN DIGESTIVE DISEASE WEEK (IDDW) 2018

The Indonesian Society of Gastroenterology (ISG)

The Indonesian Society for Digestive Endoscopy (ISDE)

Division of Gastroenterology, Department of Internal Medicine,
Faculty of Medicine Universitas Indonesia

Editor

Dadang Makmun
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FOREWORD

Dear Friends and Colleagues,

I proudly announce that Indonesian Society of Gastroenterology (ISG) in collaboration with Division of Gastroenterology, Department of Internal Medicine, Faculty of Medicine, Universitas Indonesia/Cipto Mangunkusumo National General Hospital Jakarta, organize a great event **"Indonesian Digestive Disease Week (IDDW) 2018"**.

Due to the rising challenges of gastrointestinal diseases in Indonesia, and also the advancement of tools and techniques in digestive endoscopy, we organize a scientific meeting for the exchange of knowledge and skills in the field of gastroenterology and digestive endoscopy. I hope that those who have been encountering or treating patients with gastrointestinal diseases and also practising endoscopy in their daily practices will gain more advanced and updated skills and knowledge in the field of gastroenterology and digestive endoscopy.

Hands-on Workshop on EUS/ERCP will be held at Gastrointestinal Endoscopy Center Cipto Mangunkusumo National General Hospital, Jakarta on 18 – 19 April 2018. This workshop is also supported by Asian EUS Group (AEG) and Indonesian Society for Digestive Endoscopy (ISDE). The Symposium of Indonesian Digestive Disease Week (IDDW) 2018 will be held at Borobudur Hotel, Jakarta on 20 – 21 April 2018. The symposium consists of 5 plenary lectures, 14 symposium, 3 Satellite Symposium, 2 snack with the experts, 2 meet the experts, 1 dinner symposium and poster session. Hopefully, it will provide the most updated information and knowledge in the field of gastroenterology and digestive endoscopy. All sessions will be delivered by distinguished world class international faculties and also national experts.

In this opportunity, I would like to express my sincere gratitude to Asian EUS Group (AEG), Indonesian Society for Digestive Endoscopy (ISDE), Chief Director of Cipto Mangunkusumo National General Hospital, and Dean of Faculty of Medicine Universitas Indonesia for the support to this prestigious event. I highly appreciate all international and national faculties for their great support and attention. Last but not least, I also would like to thank all sponsors and organizing committee for their contribution.

Finally, as the Chairman of **"Indonesian Digestive Disease Week (IDDW) 2018"** / President of Indonesian Society of Gastroenterology (ISG), I hope all participants enjoy this meeting and participate actively. Thank you.

Sincerely,

Prof. Dadang Makmun, MD, PhD, FACG
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INDONESIAN DIGESTIVE DISEASE WEEK (IDDW) 2018

Symposium

ROLE OF IV PPI IN THE TREATMENT OF NON VARICEAL BLEEDING

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ABSTRACT

In vitro studies of the effect of gastric pH on platelet aggregation and coagulation provide the rationale for acid suppression in UGIB. If gastric pH is maintained above pH6 (by infusional PPI), platelet aggregation is optimized and fibrinolysis relatively inhibited, thereby potentially improving the likelihood of clot stability at an ulcer site. Individual trials of H2 receptor antagonists (H2RA) have generally failed to demonstrate a clinical benefit in UGIB,[1] although one meta-analysis has suggested a weak effect.[2] A recent consensus statement suggested that the available data on H2RAs does not support their use in ulcer bleeding.[3]

Several studies have evaluated intravenous proton pump inhibitors (PPI) for non-variceal UGIB; unfortunately, these trials are heterogeneous in terms of patient population, regimen of PPI and timing/type of endoscopic intervention, making comparisons difficult. However, meta-analyses of PPIs in non-variceal UGIB have now shown a benefit in terms of re-bleeding and need for surgery, but not for mortality.[4-8] The usual intravenous regime for omeprazole therapy in the more robust studies was an 80mg intravenous bolus of omeprazole followed by a continuous infusion of 8mg/hour for up to 72 hours. This regimen resulted in a reduction of rebleeding from 22.5% to 6.7%, representing a NNT of 6 to prevent one person bleeding within 30 days.[7] Subsequent studies using lower intravenous doses of omeprazole [9] or high dose oral omeprazole [10-12] also demonstrated a reduction in rebleeding rate. Further study is required to determine the optimum dose, route of administration and dosing schedule of PPI in UGIB. In the meantime, and with the evidence currently available, it seems appropriate to treat patients with high risk peptic ulcers with intravenous or high dose oral PPI after endoscopic therapy has been administered.

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SURGICAL INTERVENTION OF DIVERTICULITIS

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ABSTRACT

Diverticulitis is characterized by inflammation of the outpouchings of the bowel wall. Diverticulitis is an increasingly common Western disease associated with a high morbidity and cost of treatment. Improvement in the understanding of the disease process, along with advances in the diagnosis and medical management has led to recent changes in treatment recommendations. Uncomplicated diverticulitis can be treated conservatively; however, complicated diverticulitis may not be responsive to medical treatment and life-threatening conditions may occur. The natural history of diverticulitis is more benign than previously thought, and current trends favor more conservative, less invasive management. Despite current recommendations of more restrictive indications for surgery, practice trends indicate an increase in elective operations being performed for the treatment of diverticulitis. Due to diversity in disease presentation, in many cases, optimal surgical treatment of acute diverticulitis remains unclear with regard to patient selection, timing, and technical approach in both elective and urgent settings. As a result, data is limited to mostly retrospective and non-randomized studies. This review addresses the current treatment recommendations for surgical management of diverticulitis, highlighting technical aspects and patterns of care.

NUTRITION IN ACUTE PANCREATITIS

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ABSTRACT

Nutrition and nutritional supplements have demonstrated necessity and importance not only in restoring energy balance but also in maintaining gut barrier function and providing important immunomodulatory and antioxidant effects.[1] The gut is an important secondary organ and also a site of starting severe systemic complications during AP. Intestinal barrier dysfunction is associated with translocation of bacteria and their inflammatory and toxic products, responsible for infection of the necrotic pancreas and systemic inflammatory responses. Therefore, maintaining the integrity of the gut barrier in the small intestine is one of the main goals in early-phase treatment of severe AP.[2] Optimal nutritional support in AP has been under debate for decades. Bowl at rest (*nothing by mouth*) strategy has been implemented conventionally to treat AP. [3,4] However, dietary restrictions exacerbate patient's malnutrition due to imbalance between reduced food intake and higher nutritional requirements, leading to further catabolism, bacterial translocation,[5] and ultimate mortality.[6] Evidence of clinical trials has demonstrated parenteral nutrition (PN) in preventing pancreatic stimulation and many benefits of enteral nutrition (EN). However, in daily practice, it remains challenging to predict whether EN will be tolerated in patients with AP.[7]

Strategic approaches to include nutritional supplements have also been attempted to provide additional immune regulatory and antioxidative effects. Probiotics and prebiotics have been shown to stabilize the disturbed intestinal barrier homeostasis and be beneficial in reducing the infection rate in primary clinical trials.[8-11] Due to the immunosuppressive and inflammatory nature of the disease, immunonutrients like glutamine and omega-3 fatty acids (ω-3 FAs) have been added to parenteral or enteral formulas to modulate immune functions, suppress the hyper inflammatory responses, and reestablish tissue and organ homeostasis in clinical practice.[12-14] Supplements with antioxidative

Mirizzi's Syndrome

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Introduction: Mirizzi's syndrome is a rare complication of gallbladder stone in which a gallstone becomes impacted in the gallbladder neck (cystic duct), causing compression of the common bile duct (CBD) or common hepatic duct, resulting in obstruction and jaundice, sometimes accompanied by the presence of cholecystocholedochal fistula.

Case Illustration: A woman aged 42 years old came to the clinic complaining a progressive yellow eye since 7 days before admission. The patient had all signs and symptoms of obstructive jaundice. Several radiologic examinations was done to find its etiology, including USG, abdominal CT Scan, and ERCP. ERCP showed a dilatation of intra and extrahepatic biliary duct, caused by large gallstone in cystic duct. During hospitalization, patient showed clinical and laboratory improvement. MRCP was done afterwards, showing that the gallstone has shifted to the lower area of cystic duct, causing no more dilatation of intrahepatic biliary duct and common bile duct despite any invasive or surgical treatment.

Discussion: Patient had been diagnosed with Mirizzi's syndrome according to its clinical, laboratory, and radiologic manifestation. Gold standard for the treatment is operation, but in this case, the patient had already showed clinical improvement without any operation. We suspected a spontaneous moving of gallstone that may improved patient clinical outcome without any surgery.

Keywords: *Mirizzi's syndrome, jaundice, gallstone*

Histoacryl Glue Injection for Treatment in Patient with Gastric Varices Non Cirrhotic Portal Hypertension

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Introduction: Gastric varices (GV) in non-cirrhotic portal hypertension is rare case. It had high morbidity and mortality rate because of profuse varices bleeding. Appropriate management was needed. We present case of GV bleeding with non cirrhotic portal hypertension.

Case Illustration: A 19-year-old male with profuse hematemesis and melena since 1 day before admission. Patient was weak, tachycardia, anemia (hemoglobin 5.3 g/dL), mild splenomegaly Schuffner 1 and Hackket 1, internal hemoroid grade 4. Abdominal Doppler ultrasound was portal hypertension and mild splenomegaly, no thrombus in vena portal and vena hepatic. Esophagogastroduodenoscopy was gastroesophageal varices (GOV 2 based on Sarin Classification). We injected histoacryl 1 mL and lipiodol 1.4 mL intravarices. Patient complain chest and abdominal pain 4 hours after procedure, and relieve with ketoprofen supposutoria 8 hours after medication. Patient get propranolol three times 10 mg daily. Endoscopic evaluation 2 months after procedure found gastroesophageal varices become smaller until a half. There was no rebleeding for 7 months after procedure.

Discussion: Hystoacryl glue injection was endoscopic variceal obturation treatment for gastric varices bleeding with a reported hemostasis rate greater than 90%. Early alertness of complications is required. Chest and abdominal pain is early complication appear 4 hours after procedure and relieve 8 hours with pain killer. In conclusion, histoacryl glue injection was one of the best definitive treatment for GV bleeding.

Keywords: *gastric varices, histoacryl, glue injection*

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Duodenal Stenting in Malignant Gastric Outlet Obstruction: Case Series

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Introduction: Gastric outlet obstruction (GOO) is a clinical syndrome leading to severe condition such as, diminished oral intake, malnutrition, decreased quality of life, and death. Unfortunately, malignancy responsible for 50-80% cases which cannot be cured. Endoscopic placement of self-expandable stents has emerged to alleviate burden and restoring oral intake in malignant GOO patients.

Case Illustration: *Case 1:* A 82 years old woman admitted due to hematemesis since 2 hours before admission. She had not have any meals, only glass of milk daily and body weight decreasing gradually. Abdominal CT scan showed gastric dilation with hypertrophic pylorus and luminal stenosis. Endoscopic procedure showed mass in pylorus. Metal duodenal stent 100 mm was placed through the mass until descending duodenum, guided by fluoroscopy. No bleeding was reported and she was able to digest soft food at hospital discharge.

Case 2: Male, 57 years old admitted due to recurrent and worsening abdominal pain. He was only able to tolerate little food. Endoscopy was performed and there was masses in antrum and corpus. Having significant hematemesis, he was then referred to our department and metallic duodenal was placed. He was able to digest some liquid food after.

Discussion: Duodenal metal stenting is a useful methods to relieve symptoms of GOO. It allows faster oral intake, less morbidity, and quicker improvement of quality of life with high technical and clinical success. Duodenal metal stent may be useful particularly in palliative settings with low life expectancy.

Keywords: *endoscopy, gastric outlet obstruction, metal stent*

Proportion Difference of Endoscopic Reflux Esophagitis in Dyspepsia and GERD Patients

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Background: Endoscopic assessment can be used for dyspepsia and GERD patients. It is crucial to classify its severity in order to determine patient's management and prognosis.

Objectives: The aim of this study is to know the number of patients with dyspepsia and GERD who were diagnosed with esophagitis. Moreover, proportion difference of endoscopic reflux esophagitis in patients with dyspepsia and GERD will be obtained.

Methods: Cross-sectional study was applied in this research. 739 patients with dyspepsia and 131 patients with GERD from 2014 to 2017 at RS Islam Jakarta Cempaka Putih, which fulfilled the requirements to undergone endoscopy, included in this research. Dyspepsia was diagnosed in accordance to Talley NJ, GERD-Q for GERD, and the Los Angeles classification for the endoscopic reflux esophagitis.

Results: From 2014 to 2017 there were 1347 patients who had undergone endoscopy. However, from that total number, there are about 64.5% (870/1347) patients who are included in this research, consist of 54.8% (739/1347) dyspepsia patients and 9.7% (131/1347) GERD patients. About 30.9% (229/739) from the total number of dyspepsia patients and 42.7% (56/131) of GERD patients were diagnosed with endoscopic reflux esophagitis. In dyspepsia patients, esophagitis grade A, B, C, D are obtained 59.8 %, 31.8%, 6.7%, 2.6%, respectively. Otherwise, in GERD patients, they are 58.9%, 33.9%, 5.3%, 1.8% ($p>0.05$, CI 95%, PR 1.663).

Conclusions: GERD patients are more likely to have endoscopic reflux esophagitis compared to dyspepsia patients. This finding should be treated based on their own endoscopic diagnosis.

Keywords: *dyspepsia, endoscopy, esophagitis, GERD, proportion, reflux*

Problem Diagnostic in a Lymphoma Colon Patient Presenting with Chronic Diarrhea

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Introduction: Colorectal lymphomas is a rare tumour of gastrointestinal tract and comprises only 0.2-1.2% of all colonic malignancies. GI lymphomas are predominantly located in the stomach (50-60%), small bowel (20-30%), and colon (10-20%), respectively. We present a rare case of patients with colorectal lymphoma.

Case Illustration: A 67-year-old man presented with chronic diarrhea with significant weight loss. The physical examination showed pale, slightly dehydrated and no palpable lymph nodes in the neck, axillae or inguinal, the abdomen was distended, tender on palpation and the bowel sounds were hipoactive. Laboratory examination showed anemia, leukocytosis, hipoalbuminemia, hypernatremia and hypokalemia. Stools were negative for ova, parasites or common pathogens. Colonoscopy was performed a solid mass ileum but biopsy reported eosinophilic colitis. He received oral sulfasalazine then was dismissed in a stable condition. Two month later, he was sent back to emergency room with a deteriorated condition. Abdominal computed tomography revealed ileocolica intusucception, homogenus enhancing intraluminal mass in caecum to colon ascenden and loculated ascites. The patient was diagnosed from surgically resected specimens due to intestinal perforation. Further, he was performed hemicolectomy and found non-Hodgkin's lymphoma from histopathology.

Discussion: Chronic diarrhea with "alarm" signs, such as bloody stools, pain or weight loss suggest malignancies. Most patients of colorectal lymphoma present with nonspecific symptoms, which often leads to advanced stage at presentation. Early diagnosis may prevent perforation and improved survival rates in patients with limited stage when treated with aggressive chemotherapy. In conclusion, a prompt diagnosis of colorectal lymphoma may be challenging.

Keywords: *colorectal, non-Hodgkin's lymphoma, colon carcinoma*

Prolonged Odynophagia Due to Esophageal Candidiasis in Immunocompetent Patient Who Frequently Self-Administered Antibiotics

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Introduction: Chronic odynophagia can be caused by esophagitis. While, esophageal candidiasis (EC) in immunocompetent patient is rare; predisposing factors such as prolonged antibiotics use must be evaluated.

Case Illustration: A-21-year-old-female visited gastroenterology clinic presenting with prolonged painful swallowing and epigastric pain. The symptoms started 6 months ago. The pain occurred every week since the last 3 months and became more painful during the post-prandial period. She denied dysphagia, weight loss, injecting-drug-use and sexual activities. She had history of frequent self-administered antibiotics such as spiramycin, amoxicillin/clavulanic-acid and levofloxacin to treat her odynophagia; antibiotic treatment was not fully relieved her odynophagia. On physical examination, she has normal vital signs, body mass index of 24.24 (overweight), normal oropharyngeal mucosa, and mild epigastric tenderness. Blood count and ECG were normal. Hepatitis and HIV test were negative. On endoscopic examination, white mucosal plaque lesions located in distal part of esophagus were found. No sign of reflux, mucosal breaks on distal esophagus and incompetent lower-esophageal-sphincter were found. Diagnosis of EC caused by frequent antibiotic use was made. She was treated with nystatin 0.5 ml tid for one week and fluconazole 150 mg once daily for 14 days. On 14 days-follow up visit, she had no complaint.

Discussion: EC may be asymptomatic or manifested as dysphagia, odynophagia, and retrosternal pain. EC should be suspected in immunocompetent patient with prolonged odynophagia and frequent antibiotics use. The esophagogastroduodenoscopy is needed to establish the diagnosis. Systemic antifungal therapy is required.

Keywords: *Esophageal candidiasis, antibiotics, prolonged odynophagia*

Prevention of Recurrent Intussuception in Peutz-Jegher Syndrome

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Introduction: Peutz-Jeghers syndrome (PJS) is a rare familial disorder (autosomal dominant). Affected 1/25000 worldwide. Characterised by mucocutaneous pigmentation, gastrointestinal and extragastrointestinal hamartomatous polyps. and an increased risk of malignancy. This complication usually manifests with abdominal pain and signs of intestinal obstruction. Other than that intussuseption is one of the Peutz-Jegher's complication that often occur.

Case Illustration: We report the case of a 34-year-old male who presented with recurrent Intussuception after bowel resection and colostomy. Patient will undergo stome reversal. Pigmentation of the lip was noted. There is no abdomal pain. colonoscpy revealed multiple polyps. Before stoma reversal, polipectomy had been done to prevent intestinal obstruction.

Discussion: Intestinal obstruction/intussuception is one of Petz-Jeghers sydrome's complication. Endoscopy with polypectomy is one of modality for management Peutz-Jegher sydrome and shoud be done routinely to prevent its complication.

Keywords: *Peutz-Jegher, complication, intussuception*

Endoscopic Submucosal Dissection in Management of in Situ Rectal Carcinoma

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Introduction: Endoscopic submucosal dissection (ESD) is a technique of endoscopic resection that allows for en bloc removal of GI epithelial lesions. ESD differs from Endoscopic mucosal resection (EMR). With EMR, the lesion is removed with a snare or suctioned into a cap and snared. With ESD, the submucosa is instead dissected under the lesion with a specialized knife.

Case Illustration: A 63 years old woman presented at our hospital with recurrent in situ rectal adenocarcinoma. The patient came with chief complain of chronic diarrhea 6 months prior to hospital admission. The first colonoscopy examination showed a laterally spreading tumor and EMR was performed. The Histopathology showed an intramucosal adenocarcinoma. The evaluation colonoscopy examination 3 month after EMR showed a recurrent rectal tumor in former resection area. Then, the ESD was performed towards the recurrent tumor. Histopathology evaluation showed no tumor towards former dissected area.

Discussion:ESD is an effective treatment modality for early-stage gastrointestinal malignancy. Compared to EMR, ESD has higher curative resections and a lower rate of local recurrence. Oncologic outcomes with ESD can be compared with surgical interventions.

Keywords*: endoscopic submucosal dissection, endoscopic mucosal resection, in situ rectal adenocarcinoma*

Ectopic Varices Due to Total Occlusion of Aorta Abdominalis

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Introduction: Ectopic varices, a highly-pressurized portosystemic venous collateral occurring anywhere in the abdomen except in the gastroesophageal area, represent natural portosystemic shunts secondary to portal hypertension. The prevalence is up to 5% of all variceal bleeding. In treating ectopic varices, intrahepatic and extrahepatic portal hypertension should be considered.

Case Illustration: Male, 47-year old, came with melena since 1 day prior to admission. First episode of melena occurred three years before hospitalization and there were nine re-bleeding episodes in which patient treated by endoscopic band ligation and argon plasma coagulation simultaneously. Endoscopic result showed esophageal varices grade I, severe portal hypertension gastropathy, antral varices, and duodenal varices in first and second part of duodenum. US examination of the abdomen showed liver cirrhosis while CT angiography of the abdomen showed total occlusion of abdominal aorta from infrarenal until proximal of inferior mesenteric artery. Splenorenal shunt surgery was performed and the result was significant.

Discussion: Ectopic varices may present with mild or massive hematemesis, melena or hematoschezia. Prompt diagnosis is important. Intravenous contrast-enhanced multislice CT and CT angiography is the primary modality to determine the etiology of ectopic varices. Therapeutic options include endoscopic band ligation (EBL), endoscopic injection sclerotherapy (EIS), transcatheter embolization or sclerotherapy. The mainstay treatment of ectopic varices is by treating the underlying causes of portal hypertension.

Keywords: *ectopic varices, splenorenal shunt, abdominal aorta occlusion.*

Isolated Pyogenic Tubercular Pancreatic Abscess Diagnosed by EUS

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Introduction: Pancreatic tuberculosis is an extremely rare clinical entity even in endemic regions. It can present as a cystic or solid pancreatic mass mimicking pancreatic malignancy. The nonsurgical diagnosis of this entity continues to be a challenge. We describe the case of successful endoscopic management of pancreatic abscesses.

Case Illustration: A 28 year old female with one-month history of intermittent epigastric vague pain, nausea and weight lost. The chest X-ray film and laboratory parameters revealed no abnormalities. Abdominal magnetic resonance imaging (MRI) examination showed a rounded isointens lesion of 2.3 × 2.2 x 2.4 cm in the head of pancreas, with no contras enhancement in the mass. The first attempts to obtain pathological evidence of the lesion by endoscopy ultrasonography (EUS)-guided fine needle aspiration (FNA) revealed pyogenic abscess in the head of pancreas. *Klebsiella pneumoniae* cultured from aspirated content of the abscesses and antibiotics were administered according to sensitivity tests. Then the symptoms improved. But one-month after that the patient suffered again the same symptoms, so the second attempts of EUS-FNA had to be done and revealed granulomatous necrotic lesions compatible with tuberculosis. The patient was put on quadritherapy (rifampicin, isoniazid, ethambutol and pyrazinamide) with a rapid clinical improvement.

Discussion: Cystic lesions of the pancreas are most commonly pseudocysts, pancreatic abscesses or cystic neoplasms. Isolated pancreatic tuberculosis is uncommon, even in areas endemic for tuberculosis. The symptoms are difficult to differentiate from symptoms due to tumours in the head of the pancreas, which occur more commonly. The diagnostic accuracy of EUS-FNA in pancreatic tuberculosis is difficult to determine due to the rarity of this entity.

The presence of granulomas in a pancreatic FNA specimen is highly suspicious of pancreatic tuberculosis. Pancreatic tuberculosis should be considered in the differential diagnosis of focal pancreatic lesions, especially for young people in developing countries. EUS-FNA is a safe and promising technique for the diagnosis of pancreatic tuberculosis, avoiding unnecessary surgery.

Keywords: *pancreatic abscess, pancreatic tuberculosis, EUS*

thromboplastin time was 46,6 with 30,7 for control. Serum natrium was low (122 mEq/L) and the result of fecal blood occult test was positive. A later CT scan showed a thickened peritoneum, and also a thickened small intestine to illeocaecal junction with limfadenopathy of mesenterial and loculated ascites in lower left abdomen region, hepatomegaly with fatty liver, and contacted gall bladder with cholelitiasis. The CT scan results suggested to peritonitis tuberculosis. USG of abdomen showed there were fatty liver, contracted gall bladder with cholelithiasis, a thickened of small intestine and minimally loculated ascites especially in left paracolic region, so paracentesis couldnot be done.

Discussion: Considering patient with chronic liver disease with elevated liver enzymes, Ethambutol 1x750 mg, Streptomicyn 1x750 mg, and Levofloxacin 1x750 mg were decided. Anti-tuberculosis was initiated given to patient without doing paracentesis for microbial cultures of ascetic fluid samples. It was considered by judgement from clinical findings and radiological findings which suggested of peritonitis tuberculosis. Initiating of anti-tuberculosis was considered in patient with peritoneal tuberculosis without microbial cultures or biopsy findings if clinical and radiological findings were suggested of peritoneal tuberculosis.

Keywords: *peritonitis tuberculosis, tuberculosis, radiological finding, computerized tomography*

Multiple Gaster, Duodenum, Jejunum Malignant Masses as Manifestations of Adenocarcinoma Lung Carcinoma Metastases

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Introduction: Adenocarcinoma cancer of lung is a common type of malignancy and it often spreads to its surrounding. The most frequent metastatic sites are nervous system, bones, liver, respiratory, and adrenal gland. Digestive system metastases from lung adenocarcinoma are rare, however, here we present an adenocarcinoma of lung which metastasized to gaster and intestinal.

Case Illustration: Male, 59 years old was admitted due to repeated black stool on defecation. Patient was known to suffer from poorly differentiated adenocarcinoma of the lung and had a lobectomy surgery a year before. Melena had persisted approximately a month and endoscopy revealed mass on the gaster with histopathology resulted as a poorly differentiated adenocarcinoma. A repeated endoscopy in Cipto Mangunkusumo Hospital showed multiple 'patchy' malignant tumor in gaster and duodenum across proximal jejunum, with active bleeding from the mass. Hemoclips were installed, argon plasma coagulation and injection of thrombin glue were performed, however, several days after, melena persisted.

Discussion: Metastases of adenocarcinoma of the lung to intraluminal digestive system is rare but possible. This kind of spreading was difficult to be treated endoscopically and surgically since the lesions were multiple with 'patchy' distribution and most all of the were easily bled. Chemotherapy was a choice, however it also had a great risk of perforation.

Keywords: *adenocarcinoma gaster, adenocarcinoma lung, metastasis, endoscopy*