From post-operative days 3 - 7 he was stable and there was no blood from the oral cavity. He was admitted for dehydration and decreased oral intake. He was treated with IV fluids, pain medications including Ketorolac, and one dose of Dexamethasone. He began taking oral intake on post-operative day 7 and was discharged home. On post-operative day 12 he presented to the ED with three episodes of bright red hematemesis that had resolved by presentation. On examination, his vitals were stable and there was no blood from the oral cavity. He was admitted for observation.

Results

On the evening of re-admission the patient had a repeat episode of hematemesis and brief episode of unresponsiveness.

On evaluation, the patient was pale with systolic blood pressure in the 80s but responsive. Blood transfusion was started and he was emergently transported to the operating room.

In the OR, the tonsillar fossa was well mucosalized and there was no evidence of bleeding from the tonsillar fossa or adenoid bed. We suctioned 400cc of fresh blood from the stomach.

Pediatric Gastroenterology was called and performed an esophagogastroduodenoscopy. Three actively bleeding duodenal ulcers were identified and were injected with epinephrine for effective hemostasis.

The patient was transferred to the pediatric ICU and started on a proton pump inhibitor drip.

He was transfused a total of 2 units packed red blood cells, 1 unit of plasma, and 1 unit of cryoprecipitate.

He underwent another EGD 3 days later which revealed ulcers with clean bases and no bleeding. Helicobacter pylori serology was negative.

After 5 days of IV proton pump inhibitor he was successfully transitioned to oral PPI.

Two months post-op he underwent a repeat EGD which showed a normal duodenum.

He was treated with an oral PPI for a total of 6 months and had no recurrence of gastrointestinal bleeding.

Conclusions

This is the first reported case of pediatric post-tonsillectomy duodenal ulcer. Pediatric gastrointestinal ulcers are more frequent in patients with risk factors such as critical illness and Helicobacter pylori infection. Our patient was at increased risk due to continued steroid and Ketorolac administration. We now advocate for high risk post-tonsillectomy patients admitted for dehydration to have stress ulcer prophylaxis.

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