Successful treatment using a side-viewing duodenoscope for esophagojejunal varices on the jejunal side of the anastomosis site after total gastrectomy

Esophagojejunal varices arising after total gastrectomy and esophagojejunal anastomosis are a rare complication of portal hypertension [1–3]. Endoscopic treatments can become challenging due to fibrosis and bleeding on the jejunal side after anastomosis. Few reports have documented the successful treatment of esophagojejunal varices after gastrectomy. We report a case of esophagojejunal variceal hemorrhage treated using a side-viewing duodenoscope.

A 67-year-old man, who underwent a total gastrectomy for gastric cancer 12 years previously, presented to our hospital with massive melena. He had a history of alcoholic cirrhosis and esophageal variceal bleeding. Abdominal contrast-enhanced computed tomography showed a dilated vein in the elevated jejunal limb supplying the varices. He was diagnosed with hemorrhage due to esophagojejunal varices. However, the varices were thin, and interventional radiology was difficult. Therefore, endoscopic treatment was attempted.

First, we performed esophagogastroduodenoscopy (EGD) (GIF-H290; Olympus Co., Tokyo, Japan), which revealed massive hemorrhage in the esophagus and jejunum (►Fig. 1). However, we could not observe the bleeding point because it was located inside the anastomosis. As cap attachment was ineffective (►Fig. 2), a side-viewing duodenoscope (JF-260V; Olympus Co.) was used.
and the bleeding point was clearly visualized on the jejunal side of the anastomosis (Video 1); however, endoscopic variceal ligation was deemed to be difficult owing to the close proximity to the anastomosis site. We therefore used clips (SureClip; Micro-Tech Co., Ltd., Nanjing, China) to treat the bleeding (Video 1). Clips could be applied easily as the bleeding point was clearly observed using the side-viewing duodenoscope.

No adverse events occurred after the endoscopic procedure. EGD 2 days post-procedure confirmed that there was no bleeding (Fig. 4). The described method had advantages over EGD as the inside of the anastomosis could be visualized with the side-viewing duodenoscope and only a change in endoscope was required.

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AG

Competing interests

The authors declare that they have no conflict of interest.

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Endoscopy 2022; 54: E484–E485
DOI 10.1055/a-1625-5369
ISSN 0013-726X
published online 8.10.2021
© 2021. Thieme. All rights reserved.
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

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