Duodenal and rectal varices as a source of severe upper and lower gastrointestinal bleeding

A 57-year old patient was admitted with hematochezia and hematemesis. The patient’s history included portal vein cavernous transformation after posttraumatic splenectomy 34 years ago. A nonbleeding elevated lesion with a small ulcer was found on the tip of a large varix (Fig. 1). Sigmoidoscopy on the following day revealed no nonbleeding rectal varices. Duplex ultrasonography confirmed portal vein cavernous transformation. Given both upper and lower gastrointestinal collateral and bleeding, portosystemic decompression was considered. However, magnetic resonance imaging (MRI) angiography could not identify a patent vein adequate for a transjugular intrahepatic portosystemic stent shunt (TIPSS) or surgical shunting. Therefore, the patient was scheduled for endoscopic therapy.

During upper endoscopy, a massive amount of blood began to spurt from the previously identified ulcerated area on the varix (Fig. 2, Video 1). The bleeding was stopped by band ligation (Fig. 3). Band ligation of the rectal varices was carried out using a gastroscope in retroflexion. The patient was stable after successful ligation, and propranolol and a proton pump inhibitor were started. Follow-up endoscopy showed scarring after band ligation without stigmata of re-bleeding (Fig. 4). Four months after band ligation, scarring is seen at the site of the previous ligation in the center of the star-shaped variceal convolute. Residual varices were again band ligated.

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Video 1

Spurting bleeding from a large varix, which was successfully stopped with band ligation.

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References

Bibliography
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