
Bleeding Gastric Varices without Obvious Esophageal Varices due to Hepatic Schistosomiasis

Sir,

Bleeding varices in the upper gastrointestinal tract are usually esophageal, sometimes gastric or both. However, bleeding gastric varices in the absence of esophageal varices have been infrequently reported. We describe a case from the South Western Region of Saudi Arabia, where schistosomiasis is endemic, and chronic bilharzial liver disease is the most common cause of life-threatening variceal bleeding.

A 60 year old Yemeni male presented with hematemesis and melena. On examination he was in shock, with a just palpable spleen. On endoscopy the esophagus appeared normal; the gastric fundus was filled with fresh blood with a suspicion of a few gastric varices in the body; the duodenum was normal. Despite vasopressin and fresh blood, the bleeding persisted. A repeat endoscopy showed the same findings and surgery was performed. Huge fundal varices were seen. The liver was shrunken and nodular, suggestive of cirrhosis, with dilated portal and splenic veins. The spleen was slightly enlarged, surrounded by adhesions and the gastroplenic ligament was shortened. There was no ascites. Splenectomy with devascularisation was performed and recovery was uneventful. Liver biopsy disclosed dense periportal fibrosis with a granuloma suggestive of schistosomiasis; no schistosomal ova were found.

Lone gastric varices have not been described in patients with portal hypertension who have not undergone sclerotherapy. However, isolated gastric varices occur in the presence of segmental portal hypertension as in situ inversus and malfatation.1 Bleeding gastric varices secondary to occlusion of the splenic vein have been described in various pancreatic diseases2,3 and wandering spleen.4,5

The explanation of obvious segmental portal hypertension in this patient remains obscure. However, we have observed while treating patients with portal hypertension due to schistosomiasis in our endemic area, that the spleen is usually surrounded by thick adhesions, and there is thickening of the tissues around it which might give rise to segmental portal hypertension.

Bleeding gastric varices should be suspected as a cause of upper gastrointestinal tract hemorrhage in patients with portal hypertension due to hepatic schistosomiasis even in the absence of esophageal varices.

References
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LETTERS

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Carcinoma of Tail of Pancreas Presenting with Intra-abdominal Hemorrhage

Sir,

Malignancies of the tail of the pancreas are relatively uncommon. Apart from severe pain, weight loss and symptoms due to metastases, several uncommon manifestations including diabetes, hematemesis and thrombophlebitis have been reported.2 The case we report here mimicked acute pancreatitis, with associated severe intra-abdominal hemorrhage.

BK, a 50 years old male, was admitted with a history of pain in the epigastrium radiating to the back, vomiting and mild distention of the abdomen. He had intermittent episodes of dull aching pain six months prior to his presentation. He was a chronic alcoholic since 20 years and there was no history of jaundice, hematemesis, steatorrhea or altered bowel habits.

On examination, he was cachectic and had severe pallor and tachycardia. Per abdomen, tenderness and minimal guarding in the epigastrium and left hypochondrium were detected. There was evidence of gross free fluid and no hepatosplenomegaly or significant lymphadenopathy. The other systems were clinically normal.

Investigations: Hemoglobin—4 g/dl, X-ray abdomen showed a ground-glass appearance, X-ray chest was normal. Serum biochemistry and liver function tests were within normal limits. Serum amylase was 200 SU. Ultrasonography of the abdomen revealed a multi-loculated collection measuring 8 cm x 10 cm with multiple echogenic areas over the body and tail of the pancreas, suggesting pancreatitis.

Conservative medical line of treatment for acute pancreatitis including blood transfusions was instituted, but his general condition worsened. An abdominal paracentesis yielded free flow of non-clotting blood suggesting hemoperitoneum. At exploratory laparotomy, 2500 cc of blood was found in the peritoneal cavity. The tail and a portion of the body of the pancreas was replaced by an extremely vascular reddish-black mass which was adherent to the adjoining structures. This mass was bleeding briskly and after its separation from the surrounding structures, a distal pancreatectomy with splenectomy was performed. The patient was recovering well from the surgery. His vital parameters were stable and his hemorrhage was well controlled. On the third day, however, he developed sudden, severe hypotension and expired. Post mortem examination revealed bilateral hemorrhagic adrenal glands. The rest of the abdominal viscera and other organs were normal. Histopathology revealed an extremely vascular, poorly differentiated adenocarcinoma of the tail of the pancreas (Fig) with lymph node metastases in the hilus of the spleen. However, the spleen and adrenal glands did not show any evidence of metastases.

Fig: Microphotograph of the tumour (H & E x 400)

The overall incidence of tumours originating in the tail of the pancreas of all pancreatic tumours varies from 6-10%.1,4 Profuse intraabdominal hemorrhage has not been reported before as a presentation of carcinoma of pancreas in our case, the tumor was essentially very vascular and bled spontaneously. Another interesting feature was that our patient presented with features of acute pancreatitis. It appears that acute adrenal failure brought about the sudden death of the patient.

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