Left hypochondrial machinery bruit is present in 61% of SAVF. SAVF should be suspected in patients with pre-sinusoidal PHT with a hepatureal flow. Doppler study, angiography and MR angiography are useful in establishing the diagnosis. Occlusion of portal vein in the arterial phase of dynamic CT offers a clue to the diagnosis. Angloembolization of low-flow fistulas with gel foam and coils in high-flow fistulas with balloons should be the primary treatment option. The role of surgery is limited to fistulas that are not amenable to embolization and fistulas near the splenic hilum, when splenectomy is an easier option.

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Duodenal metastases from squamous cell carcinoma of the lung: endoscopic management of bleeding and biliary and duodenal obstruction

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Intestinal metastases from cancer of the lung are rare. We report a 65-year-old man with duodenal metastases from squamous cell cancer causing GI bleeding and biliary and duodenal obstruction; these were managed endoscopically. [Indian J Gastroenterol 2004;23:185-186]

Key words: Gastrointestinal bleed, lung cancer; metastasis

Intestinal metastases from lung cancers are uncommon and duodenal metastases are rare. The commonest manifestations of intestinal metastases are perforation or obstruction; frank bleeding due to metastases has been reported only occasionally. Squamous cell cancer of the lung causing biliary as well as duodenal obstruction due to metastatic deposits in the ampullary region and its endoscopic management has not been reported earlier.

A 65-year-old gentleman was admitted with history of tarry stools for one day, followed by hematemesis. Five months earlier, he was diagnosed to have squamous cell carcinoma of the lung and had received chemotherapy. The patient was pale, pulse was 96/min, blood pressure was normal. There was no icterus or edema. Hemoglobin was 9 g/dL and PCV was 27.

Serum uric acid, bilirubin, transaminases, alkaline phosphatase, amylase were normal. Upper GI endoscopy revealed blood in the stomach. There was a bulky, fleshy mass in the distal first part of the duodenum with fresh bleeding from its superior aspect. Injection of 1:10,000 epinephrine resulted in stoppage of the active bleeding. Re-check endoscopy on the next day did not show any bleeding. Biopsies were obtained from the mass.

Histological examination of the tissue revealed distorted duodenal crypts with erosion of the surface epithelium at places. Small clumps of malignant squamous epithelial cells were observed in lymphatic and vascular channels (Fig).

A month later, he was readmitted with jaundice and itching since ten days. Examination revealed slight wasting with palor and icterus. Scratch marks were seen all over the body. There was no lymphadenopathy. The gall bladder was palpable and was cystic in consistency. Hemoglobin was 9.5 g/dL, serum bilirubin 188.1 mmol/L, alkaline phosphatase 664 U/L; AST and prothrombin time were normal. Ultrasonography revealed dilatation of the intrahepatic biliary radicals and the common bile duct (10 mm at the lower end). The pancreatic duct measured 7 mm. No calculi were seen in the gall bladder; parenchyma of the pancreas or the duodenum.

At ERCP, the metastatic mass in the duodenum had grown and was now also occupying the area in and around the papilla of Vater. The patient could not afford a metal stent and therefore two 10 Fr straight Cotton Leung plastic stents (Wilson Cook, Winston Salem, NC) were placed in the common bile duct. The patient became asymptomatic in three weeks. Clinically jaundice was not appreciable and the gall bladder was no more palpable. Serum bilirubin was 27.4 mmol/L and alkaline phosphatase 122 U/L.

Fig: Histology of duodenal metastases. Note malignant squamous cells in lymphatic channels and capillaries in lamina propria. Crypts of mucosa are distorted, with erosion of surface epithelium (H & E, 60 x)
Three months later, he returned with jaundice and pruritus since one week. He also complained of post-prandial fullness and vomiting of stale food. He was icteric and pale. Scratch marks were present all over the body. On abdominal examination the gall bladder was palpable and was cystic in consistency. A vague irregular abdominal lump of the dilated stomach could be palpated. A successive splash could be heard over the stomach. Hemoglobin was 8 g/dL, serum bilirubin 121.4 mmol/L and alkaline phosphatase 654 U/L.

Upper GI endoscopy revealed hyperemia and ulcers in the lower esophagus and dilated stomach with gastric residue of foul-smelling fluid and food. The second part of duodenum could not be intubated. The patient was managed by nil per os, intravenous fluids, and one unit of blood was transfused. A nasogastric tube was inserted and gastric lavage was performed with normal saline.

The next day, at ERCP, there was a tight stricture at the junction of the first and second parts of the duodenum and the side-viewing duodenoscope (TFJ V70; Olympus, Tokyo) could not be positioned in the second part. After dilation of the stricture using an over-the-wire CRE balloon (Boston Scientific, Watertown, MA), the second part could be intubated. The tumor had grown considerably and the papilla of Vater could not be identified. The plastic stents had blocked. One of them was removed using a snare. The papilla was probed using the duodenal end of the second plastic stent as a guide. The common bile duct could be cannulated and a self-expanding metal stent (diameter 10 mm, length 6 cm; Boston Scientific) was placed in the bile duct. Free flow of bile was seen. Thereafter, a 6 cm enteral stent (Boston Scientific) was placed across the duodenal stricture. Gradually, the pruritus and icterus disappeared and the patient could eat semi-solid diet till his demise five weeks later due to pulmonary complications of the lung cancer.

The chances of extra-thoracic metastases are highest with large and small cell carcinoma and least for squamous cell carcinoma. Our patient had the squamous variety in the primary as well as metastatic tumor.

Lung cancers commonly metastasize to the liver, adrenal glands, bones and kidneys. Intestinal metastases are uncommon and duodenal metastases are rare. In an autopsy study of 423 patients with primary tumor of the lung, only 58 (14%) had gastrointestinal metastases, none of them in the duodenum. A majority of these patients were asymptomatic as far as the metastases were concerned. However, there have also been instances of duodenal metastases, from cancer of the lung, being the presenting symptom. If all metastatic tumors of the gastrointestinal tract are considered, melanoma, cancer of the lung and breast cancers are the commonest primary tumors that metastasize to the gastrointestinal tract.

Occult bleeding from duodenal metastases from cancer of the lung has been reported and on occasion these have bled from a superior mesenteric artery-duodenal fistula. Frank bleeding from the metastatic deposits in the duodenum, as was evident in this patient, has been rarely reported. In that report active bleeding had stopped and therefore no endoscopic intervention was performed.

There is a report of successful pancreaticoduodenectomy for metastatic small cell cancer of the lung. The metastases was at the ampullary area. We are not aware of any report where metastatic deposit from squamous cell cancer of the lung led to obstruction of the biliary ductal system as well as the duodenum.

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Endoscopic band ligation for non variceal bleed

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Endoscopic band ligation (EBL) is an infrequently used modality for treatment of non-variceal hemorrhage. We report the successful use of this technique for the management of bleed from blue rubber bleb nevus syndrome lesions and post polypectomy bleeding stalk. [Indian J Gastroenterol 2004;23:186-187]

Key words: Blue rubber bleb nevus syndrome, rectal polyp

Endoscopic band ligation (EBL) has recently been used for the treatment of non variceal bleed. Blue rubber bleb nevus syndrome and post polypectomy bleeding stalk have been conventionally treated with surgery or modalities like argon plasma coagulation,