laser photocoagulation or bipolar electrocoagulation.

We describe the use of EBL for management of these conditions.

Case 1: A 15-year-old boy presented with recurrent hematemesis for 6 months. Examination revealed three elevated bluish lesions on the buttocks. Endoscopy showed four lesions (each approximately 0.5 cm in diameter) in the antrum, similar to the skin lesions. Barium follow-through study was normal. Colonoscopy was normal up to the cecum. The patient was diagnosed as a case of blue rubber bleb nevus syndrome. Endoscopic band ligation of the four antral lesions was performed in two sessions. Ligation led to immediate discoloration of the lesion, which turned bluish after 30 minutes. It was replaced by an ulcer after 10 days (Fig). The patient was followed up for 6 months without recurrence of bleed.

Case 2: A 12-year-old boy presented with rectal bleed for 6 months. Colonoscopy revealed a 1.5 cm pedunculated rectal polyp. The polyp underwent autoamputation during snaring, before passing the electrocautery current, leading to bleed. Endoscopic ligation of the stalk was performed using a gastroscopy and ligator instrument. There was immediate arrest of bleeding. One week later the stalk was replaced by an ulcer. The patient remained asymptomatic thereafter for 1 year.

Endoscopic electrocautery or laser photocoagulation have been recommended for the management of blue rubber bleb nevus syndrome lesions.\(^1\) Treatment with band ligation and sclerotherapy has also been described.\(^2\) We successfully managed these lesions with band ligation.

Bleeding after polypectomy is seen in up to 2% of cases and is commoner with polyps with large stalk, sessile polyps, after autoamputation of polyp, and when pure current is applied during polypectomy. Hemoclips, argon plasma coagulation, heater probe and injection of adrenaline have been tried. Few reports are available documenting the role of band ligation without any delayed bleeding.\(^3\) The advantages of band ligation are the low cost, easy availability and ease of application.

References

---

Leino-renal collaterals causing left pelviureteric junction obstruction

Malappally Chowda Balaji Reddy,
Aroop Jyoti Kalita, Chandreshkar Reddy,*
Varughese Mathai**

Departments of Radiology, **Gastroenterology, and
**Surgical Gastroenterology, Global Hospitals, 6-1-1070,
Lakdi ka Pool, Hyderabad 500 004

Pelviureteric junction obstruction of the kidneys secondary to crossing renal vessels is a known entity. We report a 26-year-old woman with obstruction secondary to portosystemic collaterals; she was incidentally detected to have extrahepatic portal vein obstruction. [Indian J Gastroenterol 2004;23:187-188]

Key words: Portal hypertension

Pelviureteric junction (PUJ) obstruction can be due to intrinsic or extrinsic causes. Obstruction secondary to crossing renal vessels has been reported earlier.\(^1\) A 26-year-old woman presented with pain in the left loin since 6 months. Ultrasonography revealed left hydromephrosis secondary to PUJ obstruction. The right kidney was normal. Splenomegaly was noted with multiple perisplenic collaterals. The left lobe of liver was hypoplastic with multiple small collaterals in the portal vein region (portal cavernoma). Intravenous urography showed normal right kidney and ureter. Gross left-sided hydromephrosis was noted with double bubble sign, that is, filling of the renal pelvis and the proximal segment of ureter stented to it without filling of the ureter distal to it. This sign is suspicious of crossing renal vessels, hence the patient was referred for CT angiography.

CT angiography showed normal renal arteries. The left kidney showed gross hydromephrosis with thin parenchyma. Multiple collaterals were seen in the region of the portal vein with no definite portal vein. The left lobe of liver was hypoplastic, with calcific foci in the liver and spleen, along with splenomegaly and multiple perisplenic collaterals. The splenic

Indian Journal of Gastroenterology 2004 Vol 23 September - October 187
Spleen-preserving distal pancreatectomy following neoadjuvant chemotherapy for papillary solid and cystic neoplasm of pancreas

Ganesh Das, Chidananda Bhuyan,*
Bhabesh Kumar Das, Jagannath Deb Sharma,**
Bhargab Jyoti Saha,** Joydeep Purkayastha

Departments of Surgical Oncology, *Medical Oncology and **Pathology, Dr Bhaskarwar Borobodh Cancer Institute, Gopinath Nagar, Guwahati 781 016, Assam

Papillary solid and cystic neoplasm (PSCN) is a rare neoplasm of the pancreas with low-grade malignant potential and favorable prognosis. We report an 18-year-old girl with PSCN presenting with advanced disease. The tumor regressed with six cycles of gemcitabine and cisplatin-based neoadjuvant chemotherapy; spleen-preserving distal pancreatectomy was done. She is disease-free at 13 months' follow-up. [Indian J Gastroenterol 2004;23:188-189]

Key words: Cisplatin, gemcitabine, pancreas tumor

Papillary solid and cystic neoplasm is a rare neoplasm of the pancreas, usually occurring in young patients.1,2 The main treatment is surgery; the role of chemotherapy and radiotherapy is not well defined. They generally have a favorable prognosis.

An 18-year-old girl presented with pain and mass in the abdomen for 6 months. On examination, all systems were within normal limits except for a huge mass in the left hypochondrium. Laboratory investigations were normal. CT scan (Fig) showed a large soft-tissue mass (10.9 cm x 6.8 cm) arising from the body and tail of the pancreas with multiple calcifications, a few areas of necrosis and cystic changes, with posterior gastric wall infiltration and para-aortic lymphadenopathy. Ultrasound-guided FNAC showed papillary neoplasm. Since the tumor appeared unresectable, she was started with gemcitabine and

Correspondence to: Dr Reddy. Fax: (40) 2324 4455. E-mail: mcbalaji@hotmail.com
Received February 14, 2004. Accepted June 13, 2004