Case Report

Bleeding Ectopic Varices as the First Manifestation of Portal Hypertension

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Ectopic varices are defined as dilated portosystemic collateral veins in locations other than the gastroesophageal region. We present a case of recurrent upper gastrointestinal bleeding as the first manifestation of portal hypertension. We diagnosed ectopic duodenal varices without gastroesophageal varices on upper GI endoscopy and extrahepatic portal venous obstruction (EHPVO) on CT angiography and managed this case.

1. Introduction

Ectopic varices are defined as dilated portosystemic collateral veins in locations other than the gastroesophageal region [1, 2]. Ectopic varices account for 1% to 5% of all variceal bleeds in patients with intrahepatic portal hypertension and 20% to 30% of those with extrahepatic portal hypertension [1]. Ectopic varices have been reported to occur at numerous sites, including 18% in the jejunum or ileum, 17% in the duodenum, 14% in the colon, 8% in the rectum, and 9% in the peritoneum [3]. Ectopic varices present a clinical challenge as the etiology is multiple, localization is variable, modality of detection is heterogeneous, presentation is diverse, and management guidelines are not clear. We present a case of recurrent upper gastrointestinal bleeding, detected ectopic duodenal varices without gastroesophageal varices on upper GI endoscopy, and confirmed extrahepatic portal venous obstruction (EHPVO) on CT angiography. The case is presented to highlight the clinically challenging condition of ectopic varices, to have a high clinical suspicion to make the diagnosis especially in a patient with recurrent upper GI bleeding without history of chronic liver disease or stigmata of portal hypertension and normal upper GI endoscopy and may be the first manifestation of underlying portal hypertension as in our case.

2. Case History

A 32-year-old male presented with history of hematemesis followed by melena for 3 days. History of dizziness on getting up from sitting position was present for one day. No history of pain abdomen, jaundice, drug intake, weight loss, or loss of appetite was present. In past history patient had two episodes of GI bleed in the last 2 years. Upper GI endoscopy outside this hospital was reported to be normal. There was no history of abuse or addiction. Review of other systems was normal. General physical examination revealed pallor and tachycardia and blood pressure measurement documented a postural fall of 20 mmHg. The rest of the general physical examination was normal and no stigmata of chronic liver disease were present. On systemic examination, spleen was palpable 2 cm below the left costal margin. The rest of the systemic examination was normal. On investigation, the hemoglobin was 7.6 gm% and platelet count was 1.6 lac/cmm. Blood glucose and renal functions were normal. Total serum bilirubin was 0.6 mg%. Serum total proteins were 6.3 gm% and albumin was 3.9 gm%. AST was 54 IU and ALT was 62 IU and alkaline phosphatase was 62 KAU. Upper GI endoscopy revealed fresh blood in the stomach (Figure 1(a)). A large varix with active spurt was observed in D1 part of duodenum (Figure 1(b)). One mL of N-butylcyanoacrylate was injected

is a recommended option if endoscopic techniques and interventional radiologic procedures fail to control bleeding or are not feasible, provided the underlying good liver function and the local expertise. Surgery is preferred in patients with Child-Pugh “A” cirrhosis and in patients with an EHPVO [1, 5].

For secondary prophylaxis of bleeding in extrahepatic portal venous obstruction performing a lienorenal shunt with splenectomy carries a low operative mortality of 1%, a rebleeding rate of about 10%, shunt thrombosis rate of <2% over a 15-year followup, and survival rates of >96% after 10 years, is not followed by portosystemic encephalopathy and improves quality of life. Most importantly, it is a onetime procedure particularly suited to those who have little access to blood transfusion and sophisticated medical facilities [8].

To conclude, physicians need a high clinical index of suspicion to make the diagnosis of ectopic varices and be especially vigilant in patients with liver disease, as bleeding ectopic varices may be the first manifestation of underlying portal hypertension.

Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

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