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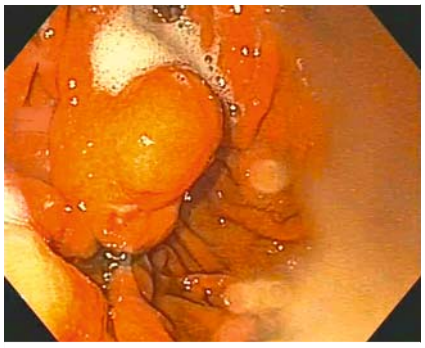
Endoscopy E-Videos

Endoscopic ultrasound-guided angiotherapy in refractory gastrointestinal bleeding from large isolated gastric varices: a same-session combined approach

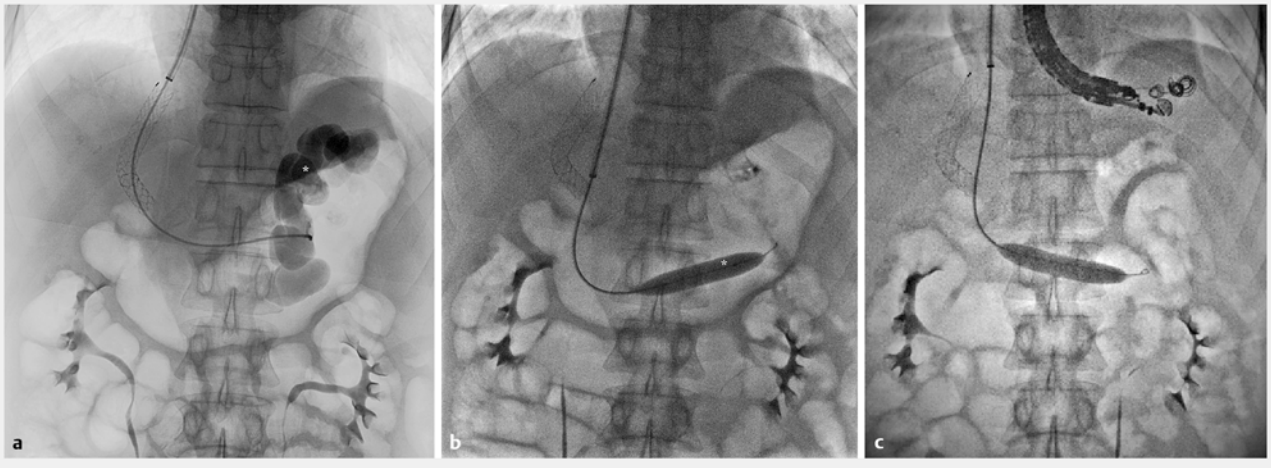
A 36-year-old Asian man with severe portal hypertension due to hepatitis B virus-related cirrhosis had been previously treated for acute gastrointestinal bleeding from a large isolated gastric varix (IGV-1) by injection of endoscopic cyanoacrylate glue at a local hospital (▶ **Fig. 1**). Following an episode of massive recurrent hematemesis, the patient was hemodynamically stabilized and referred to our institute. Radiological evaluation revealed the presence of numerous collaterals in the gastric fundus with a large-caliber splenorenal shunt.



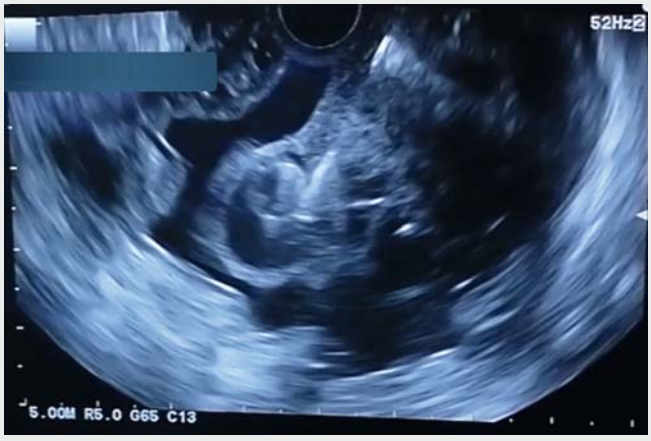
▶ **Fig. 1** Endoscopic view of a large isolated gastric varix (IGV-1) with signs of recent glue injection.

With the patient under general anesthesia, it was found that the portal gradient did not decrease significantly with a transjugular intrahepatic portosystemic shunt (TIPS) positioned across the left hepatic and left intrahepatic veins [1], confirming that blood outflow was predominantly diverted towards the shunt (▶ **Fig. 2a**). We then decided to use a same-session combined technique involving balloon-occluded retrograde transvenous obliteration (B-RTO) of the left renal vein [2] and selective endoscopic ultrasound (EUS)-guided variceal embolization [3, 4] by coils and n-butyl-2-cyanoacrylate (CYA) injection.

A B-RTO was performed to obliterate the left renal vein before EUS-guided selective treatment in order to protect the pulmonary circulation from systemic embolization (▶ **Fig. 2b**). Gastric varices (IGV-1) were then visualized from the stomach with a linear-array echoendoscope. Selective EUS-guided intravascular puncture was performed with a 22-gauge fine needle aspiration (FNA) needle (EZ Shot 3 Plus; Olympus Europe) and three 0.018-inch coils (MReye Embolization Coil; Cook Medical) were released through the needle under EUS and fluoroscopic control (▶ **Video 1**), the endovascular coils being advanced into the targeted vessel using the pushing ac-



▶ **Fig. 2** Radiographic images showing: **a** contrast medium injected via a catheter inserted through the transjugular intrahepatic portosystemic shunt (TIPS) into the splenic vein, which confirmed portal outflow in the direction of a large splenorenal shunt (asterisk); **b** a balloon-occlusion catheter (asterisk) that had been advanced through the internal jugular access and positioned in the left renal vein to give protective closure of the efferent limbs of gastric varices; **c** EUS-guided selective embolization, with spiral coils (from 4 – 8 cm in length) having been selectively released according the size and axis of the gastric varix.



Video 1 Refractory bleeding from isolated gastric varices is successfully treated in a same-session combined approach using transjugular intrahepatic shunt (TIPS) placement, balloon-occluded retrograde transvenous obliteration (B-RTO), and endoscopic ultrasound (EUS)-guided variceal embolization by coils and cyanoacrylate glue injection.

tion of the stylet. Following the complete deployment of each coil, 1 mL of CYA, 3 mL of Lipiodol, and 10 mL of 5 % glucose solution were injected through the needle into the varix creating a full thrombosis. We released a total of three coils (▶ **Fig. 2 c**) with complete variceal embolization as confirmed by a negative color Doppler scan. No adverse events or rebleeding had been reported at 12 months of follow-up.

EUS-guided coil placement with CYA injection is a feasible and effective additional procedure following TIPS placement in selected patients with severe portal hypertension and refractory bleeding from large IGV-1 varices.

Endoscopy_UCTN_Code_TTT_1AS_2AG

Competing interests

None

The authors

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DOI https://doi.org/10.1055/s-0043-107611
Online-Publikation: 3.7.2018
Endoscopy 2018; 50: 1033–1034

Stuttgart · New York
ISSN 0013-726X