Endoscopic clipping prior to n-butyl-2-cyanoacrylate injection for gastric varices with a large gastrorenal shunt

A 56-year-old man was admitted to our department with a diagnosis of esophageogastric variceal hemorrhage and decompensated post-hepatic cirrhosis. Emergency gastroscopy revealed a huge gastric fundal varix with hemorrhagic spots (Fig. 1). The diameter of the gastrorenal shunt was 11.5 mm on computed tomography (CT) scanning (Fig. 2). Endoscopic treatment was performed immediately. We planned to deploy five clips (Instinct; Cook Medical, Bloomington, Indiana, USA) on the varix (Fig. 3).

Specifically, the first clip was deployed on the afferent branch of the varix. Deployment of the third clip caused the vessel to be broken and a little blood oozed out. A fourth clip was applied on the efferent branch of the varix. Finally, because of the large intravenous cavity on the upper part of the vein, the last clip was placed on the cavity, so as to reduce the volume of cyanoacrylate required.

After the clips had been placed, a “modified Sandwich method” (lauromacrogol, n-butyl-2-cyanoacrylate, and sodium morrhuate) was used to complete the procedure. We injected the mixture on top of the broken point, and the bleeding quickly stopped. Two additional points were injected on each side of the first injection point and then one on the efferent branch until the whole varix had been solidified (Video 1). A total of 8 mL n-butyl-2-cyanoacrylate (Histoacryl; B. Braun, Melsungen, Germany), 25 mL lauromacrogol (Tianyu Pharmaceutical Co. Ltd., Shanxi, China), and 10 mL sodium morrhuate were used during the procedure.
A follow-up CT scan 2 weeks later showed the blocked gastric varix and gastrorenal shunt (▶ Fig. 4). No bleeding or systemic embolism were reported during the 4-month follow-up period (▶ Fig. 5).

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Competing interests

None

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