A 30-year-old man presented with hema-
temesis. Five years earlier, he had been di-
agnosed with *Escherichia coli* liver absces-
ses, without a clear underlying cause be-
ning identified. Although he recovered with antibiotic treatment, extensive
thrombosis of the portal, splenic, and hu-
perior mesenteric veins remained. The pa-
tient received prophylactic propanolol for
large fundic varix, and oral anticoagu-
lants during the first year as well. Endo-
scopic evaluation during the current ad-
mission revealed bleeding from the fundic
varix, and an injection of 1 ml *N*-butyl-2-
cyanoacrylate (enbucrilate, Histoacryl),
0.5/0.8 (v/v) diluted with Lipiodol, was ad-
ministered. Although the hemorrhage was
temporarily stopped, repeated cyanoacry-
late injections (two injections of 1 ml) and
subsequent placement of a Sengstaken−
Blakemore tube had to be carried out due
to recurrent severe bleeding.

The same day, a partial gastrectomy,
splenectomy, and esophageal transection
were performed. Postoperative chest ra-
diography (Figure 1, left) and computed
tomography (Figure 1, top right) revealed
multiple cyanoacrylate pulmonary em-
boli. Mechanical ventilation had to be
started. Abdominal sepsis from a sub-
phrenic abscess, with multiple organ fail-
ure, subsequently occurred. Intravenous
heparin therapy was started due to deep
vein thrombosis in both legs. The patient
showed further pulmonary deterioration
(Figure 1, bottom right). Thirty-seven
days after the initial sclerotherapy, he
died of abdominal sepsis and deteriora-
ting pulmonary function. No recurrent
bleeding had occurred since the surgical
procedure.

Although cyanoacrylate is generally re-
garded as the first-line treatment for
bleeding gastric varices [1], complications
may occur, such as the needle adhering to
the varix, pyrexia, deep ulceration due to
accidental paravariceal injection, and in
particular pulmonary embolism [2, 3].
Risk factors for pulmonary embolism are:
more than 1 ml cyanoacrylate−Lipiodol
per injection, excess Lipiodol (cyanoacy-
late/lipiodol ratio below 5 : 8 v/v), injec-
tion of excess distilled water with the
needle still located in the varix [4], and
slow injection, especially in case of vari-
ces with a high flow rate and a large diam-
eter [5]. Surgery is still a valuable treat-
ment alternative, especially in cases of
left−sided portal hypertension.

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