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COLLATERAL THINKING

Editor,

We present a rare and challenging case of a patient presenting with ectopic variceal haemorrhage. A 57 year old man with a background of alcohol related liver cirrhosis (Child Pugh A6, MELD 10) presented with 3 episodes of frank bleeding from his umbilicus over a 4 day period. Variceal surveillance with OGD in March 2017 was negative and other significant medical history included alcohol dependence, morbid obesity, type 2 diabetes mellitus and COPD.

Abdominal examination showed caput medusae that had been oversewn in the emergency department; there was no detectable ascites or asterixis. Doppler ultrasound of liver revealed patent hepatic vasculature. Subsequent CT confirmed cirrhotic appearances of the liver with features of portal hypertension, recanalisation of the umbilical vein and varices measuring up to 2cm in diameter within an umbilical hernia (Figure 1 and 2).

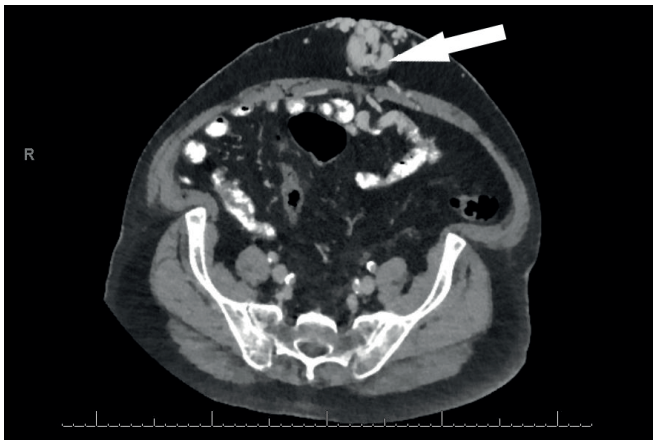

Fig 1. CT showing sizeable umbilical varices (white arrowhead)

Following a further episode of bleeding from the umbilicus 48 hours post-admission, his haemoglobin fell from 113 g/L (130 – 180 g/L) to 62 g/L. He was managed as per gastro-intestinal variceal haemorrhage with transfusion of packed red cells, terlipressin and prophylactic antibiotics.

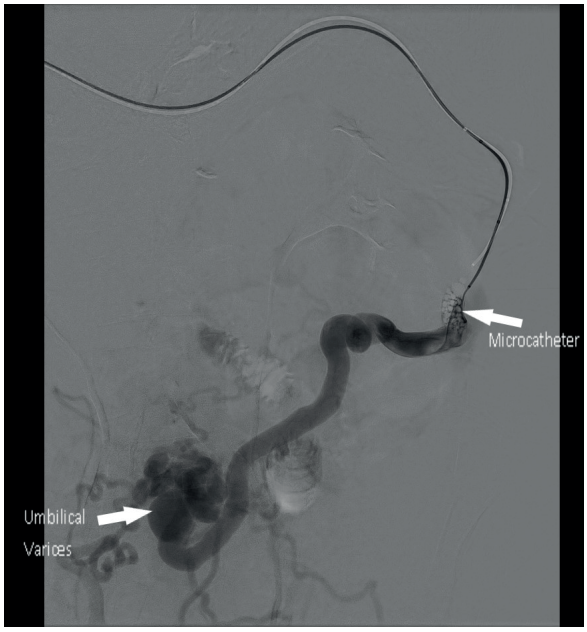

Fig 2. Catheterisation of umbilical varices

To prevent further bleeding a transjugular intrahepatic portosystemic shunt (TIPSS) was arranged. An echocardiogram, performed as part of a pre-TIPSS work-up, established that biventricular function was normal. He remained haemodynamically stable and proceeded to TIPSS (Figure 3) which proved to be technically successful with the aid of CT fusion imaging (Figure 4). A significant hepatic venous pressure gradient in excess of 30 mmHg was recorded prior to stent deployment. Venography demonstrated a large portosystemic collateral vessel which eventually reached the level of the multiple varices at the patient's umbilicus. A

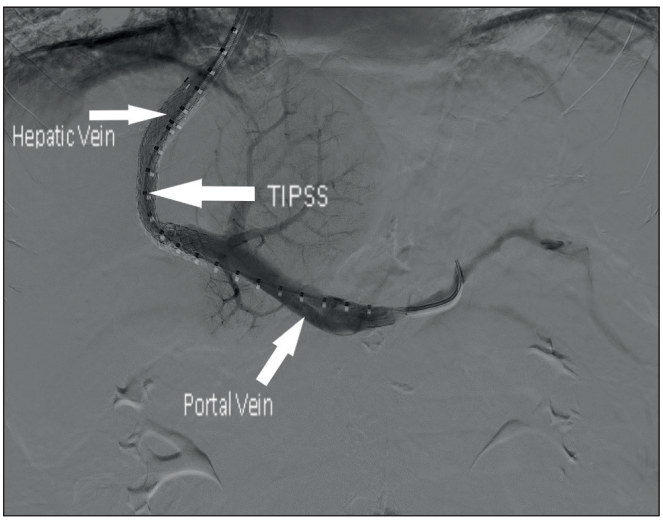

Fig 3. TIPSS insertion

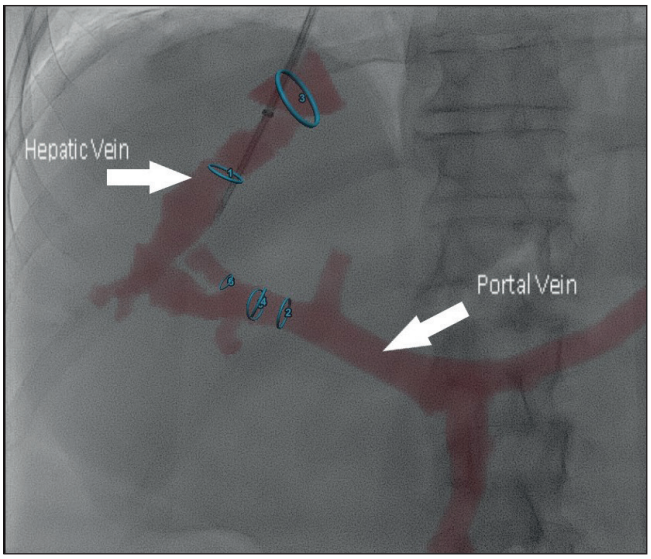

Fig 4. CT guided fusion imaging

microcatheter was negotiated along this allowing coiling and fibrovein foam embolisation (Figure 2). Following TIPSS and embolization (January 2018) bleeding was controlled and the patient was successfully discharged.

To date, liver cirrhosis remains compensated with no post TIPSS hepatic encephalopathy in spite of relapse to low level alcohol consumption. He is currently Child Pugh A5 offering a 1 year survival of 95% and 2 year survival of 85%. No further variceal surveillance is required as portal hypertension has been addressed.

Gastroesophageal variceal bleeding is a common complication of patients with chronic liver disease. Bleeding from any location where there are portosystemic anastomoses and collateral vascular formation is possible.[1] Variceal bleeding from locations other than the gastrointestinal tract (ectopic variceal bleeds) whilst rarely considered, account for up to 5% of all variceal bleeding. In addition, haemorrhage can be massive with mortality reaching up to 40%.[2]

Treatment is generally guided by local expertise due to absence of large studies. Initial interventions such as suture haemostasis and cauterisation have success for only a limited time frame. Medical treatments implemented to lower portal pressure include vasoconstrictors (terlipressin) in the acute setting and beta blockers (propranolol, carvedilol) in the chronic setting.[1, 2, 3]

Radiological interventions such as shunting (TIPSS) and percutaneous umbilical vein embolisation with sclerotherapy have been documented. A greater than 50% reduction in pressure gradient has been demonstrated to protect patients from rebleeding.[1]

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PRIMARY PANCREATIC LYMPHOMA

Editor

We present a case of a rare primary pancreatic malignancy which provides a challenging diagnosis given a non-specific presentation and lack of unique identifiers on imaging.

An 80-year-old gentleman presented with painless jaundice (Bilirubin 85 µmol/l, Alkaline Phosphatase 235 U/L, Aspartate Aminotransferase 124 U/L, Alanine Aminotransferase 132 U/L, and Gamma-Glutamyl Transferase 326 U/L).

Abdominal ultrasound confirmed a large mass related to the head of the pancreas. Computed Tomography (CT) chest, abdomen and pelvis showed a pancreatic mass with vascular involvement and presence of a gastric antrum lymph node.

Endoscopic Ultrasound (EUS) with Fine Needle Biopsy (FNB) of the pancreatic mass was performed (Figure 1 and Figure 2). Figure 1 shows a 3.7cm hypoechoic mass with no vascularity on Doppler imaging, suggesting that the mass is not a neuroendocrine tumour. Figure 2 shows the mass infiltrated by a biopsy needle and a smooth non-infiltrative border, atypical of adenocarcinoma.

Histology and immunochemistry of the pancreatic mass confirmed a high-grade B cell Non-Hodgkin's Lymphoma stage IV A.

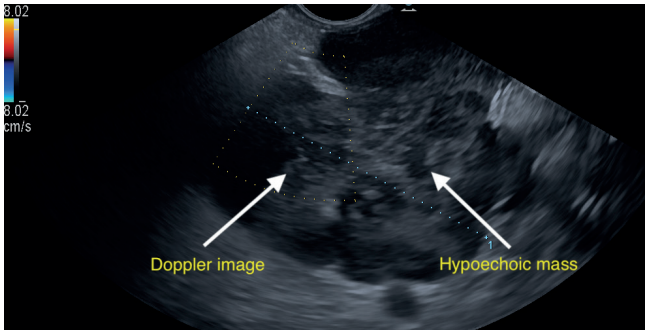

Figure 1