

# Development of Gastric Varices

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## Description

Gastric varices are an important Porto systemic collateral pathway, occurring in ~20% of patients with portal hypertension. They are considered distinct from oesophageal varices in that they have a propensity to haemorrhage at comparatively lower portal pressures, and are also associated with higher mortality rate with hemorrhage. The patients with cirrhosis or high portal blood pressure are highly prone to gastric variceal bleeding than the patients with splenic vein thrombosis (SVT). The bleeding leads to heavy loss of blood, which should be compensated by blood transfusion to regulate the blood circulation and to maintain the hemoglobin level 7-8 g/dL. This technique is a recovery approach to lower the risk of rebleeding and mortality. Gastric varices are treated by primary prophylaxis and secondary prophylaxis. The primary treatment includes drug therapy.

Gastric varices are less common than esophageal varices in patients with portal hypertension, occurring in up to 33% of patients. Gastric varices are more common in patients with noncirrhotic portal hypertension and extra hepatic portal vein thrombosis, are associated with a lower incidence of bleeding, and have a higher mortality rate than esophageal varices. Optimal management of gastric variceal bleeding is debatable, because of lack of data from large randomized controlled trials. Gastric variceal bleeding may be caused by portal hypertension or splenic vein thrombosis. In the context of portal hypertension, emergency TIPS is often successful in controlling hemorrhage.

Splenectomy is often reserved for patients with isolated splenic vein thrombosis, and in the context of multiple splanchnic and portal thrombosis, treatment is more complicated. We report that splenectomy was a successful treatment for this patient with gastric varices and multivessel extra hepatic thrombosis secondary to essential thrombocythemia. Gastric variceal bleeding may be caused by portal hypertension or splenic vein thrombosis. In the context of portal hypertension, emergency TIPS is often successful in controlling.

Thrombosis may be candidates for splenectomy or splenic embolization as a means of definitive therapy; however, data are scarce. Other endoscopic treatments have also been used to prevent rebleeding. Sclerotherapy has been abandoned because of high rebleeding rates (50%–90%). Variceal band ligation may be used for those patients with GOV1 and in some cases of small GOV2, and it is generally performed every 2 weeks until apparent endoscopic obliteration. However, band ligation is limited by the fact that it cannot be used in large GOV2 or IGV1.7 Detachable loop snares to treat large GV (>2 cm) along with propranolol have resulted in low rebleeding rates; however, data are very scarce, and the procedure is labor intensive.

This approach has not been further evaluated and has not been compared with other modalities and thus cannot be routinely recommended. Endoscopic ultrasound guided treatment is a new modality for treatment of GV and this has emerged as a valuable tool for diagnosis, treatment planning, evaluation of treatment efficacy, estimation of recurrent bleeding potential and also helps visualize varices, perforating veins, collateral veins and allows predict varices at high risk. Romero-Castro et al. in their small case series injected cyanoacrylate-lipiodol into GV at the level of perforating veins, under EUS guidance. All the procedures were successful, without recurrent bleeding or other complications during follow up. They postulated that targeting perforating veins would produce the maximal blood-flow blockage, with the lower amounts of cyanoacrylate needed, therefore reducing the rate of potential local and systemic complications.

## Conclusion

Gastroesophageal reflux disease (GERD) occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach (esophagus). This backwash (acid reflux) can irritate the lining of your esophagus. In most people, GERD doesn't cause serious complications. But in rare cases, it can lead to serious or even life-threatening health problems.

In most cases, lifestyle changes and medications are enough to prevent and relieve symptoms of GERD. But sometimes, surgery is needed. For example, your doctor might recommend surgery if lifestyle changes and medications alone haven't stopped your symptoms. They might also suggest surgery if you've developed complications of GERD. There are multiple types of surgery available to treat GERD.

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