Title:
Gastric variceal bleeding as a form of presentation of a pancreatic neuroendocrine tumor

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Dear Editor,

Neuroendocrine tumors (NETs) constitute a heterogeneous group of epithelial-type neoplasms with a predominantly neuroendocrine differentiation. Although the most common locations are the pancreas, digestive tract and lung, this type of neoplasm can arise in virtually any organ in the body (1). They are rare tumors with a wide variety of clinical presentations (2). Symptomatic tumors are more frequent in younger patients and present at more advanced pathological stages (3).

Case report

We present the case of a 42-year-old male with idiopathic splenomegaly and bicytopenia (anemia and thrombocytopenia) under study by the Hematology Department, who was admitted due to an episode of melena and a hemoglobin level of 4.5 mg/dl. Isolated gastric varices (IGV1) with red spots (Fig. 1A) were confirmed by
gastroscopy, and endoscopic variceal obturation using cyanoacrylate was performed in two sessions. An endoscopic ultrasonography was performed, showing thrombosis of the splenic vein extending towards the splenoportal confluence with anechoic serpiginous structures outside and inside the gastric wall, suggestive of collateral circulation with gastric varices (GV). An increase in portal caliber was observed, with no signs of liver cirrhosis. Computed tomography confirmed the findings.

Subsequently, the patient was readmitted with rebleeding signs after starting anticoagulant treatment, so a splenectomy was performed due to failure of the endoscopic treatment. Histology revealed infiltration of the spleen by a well-differentiated NET. Gallium positron emission tomography/computed tomography (PET/CT) and octreotide scan showed uptake in the body and tail of the pancreas which was positive for somatostatin receptors previously undetected by other means. Finally, treatment was completed with a distal pancreatectomy and splenoportal axis thrombectomy with vascular splenic resection, and the patient was discharged from hospital.

Discussion
GV bleeding is a rare complication of portal hypertension, but it is typically more severe with a higher mortality than other portal hypertensive bleeding (4). The optimal treatment for GVs remains open for study. Endoscopic management using N-butyl-2 cyanoacrylate has shown a high reduction rate for acute control of bleeding and early rebleeding (5). Therefore, the most recommended therapeutic option in cases of symptomatic left portal hypertension is splenectomy and correction of the primary cause if possible. In these patients, considering other causes of portal hypertension, such as splenic vein thrombosis and obstruction, and the possibility of an underlying malignancy is crucial.

References


Fig. 1. A. Esophagastroduodenoscopy (EGD) in retroflexed view revealed gastric varices with red spots in the fundus. B. Anechoic serpiginous structures outside and inside the gastric wall suggestive of collateral circulation by endoscopic ultrasound (EUS). C. The splenic vein appears dilated with intraluminal echogenic material and no signal on color Doppler consistent with thrombosis by EUS. D. Octreotide scan showing uptake in the body and tail of the pancreas.