Three months later, he returned with jaundice and pruritus since one week. He also complained of post-prandial fullness and vomiting of bile food. He was icteric and pale. Scratch marks were present all over the body. On abdominal examination the gall bladder was palpable and was cystic in consistency. A vague upper abdominal lump of the dilated stomach could be palpated. Suction splash could be heard over the stomach. Hemoglobin was 8 g/dL, serum bilirubin 121.4 mmol/L and alkaline phosphatase 654 U/L.

Upper GI endoscopy revealed hyperemia and ulcers in the lower esophagus and dilated stomach with gastric residue of foul-smelling fluid and food. The second part of duodenum could not be intubated. The patient was managed by nil p.o., intravenous fluids, and one unit of blood was transfused. A nasogastric tube was inserted and gastric lavage was performed with normal saline.

The next day, at ERCP, there was a tight stricture at the junction of the first and second parts of the duodenum and the side-viewing duodenoscope (TJF V130; Olympus, Tokyo) could not be positioned in the second part. After dilation of the stricture using an over-the-wire CRE balloon (Boston Scientific, Watertown, MA), the second part could be intubated. The tumor had grown considerably and the papilla of Vater could not be identified. The plastic stents had blocked. One of them was removed using a snare. The papilla was probed using the duodenal end of the second plastic stent as a guide. The common bile duct could be cannulated and a self-expanding metal stent (diameter 10 mm, length 6 cm; Boston Scientific) was placed in the bile duct. Free flow of bile was seen. Thereafter, a 6 cm enteral stent (Boston Scientific) was placed across the duodenal stricture. Gradually, the pruritus and icterus disappeared and the patient could eat semi-solid diet till his demise five weeks later due to pulmonary complications of the lung cancer.

The chances of extra-thoracic metastases are highest with large and small cell carcinoma and least for squamous cell carcinoma.1 Our patient had the squamous variety in the primary as well as metastatic tumor.

Lung cancers commonly metastasize to the liver, adrenal glands, bones and kidneys.1 Intestinal metastases are uncommon and duodenal metastases are rare.1,6 In an autopsy study of 423 patients with primary tumor of the lung,1 only 58 (14%) had gastrointestinal metastases, none of them in the duodenum. A majority of these patients were asymptomatic as far as the metastases were concerned. However, there have also been instances of duodenal metastases, from cancer of the lung, being the presenting symptom.6 If all metastatic tumors of the gastrointestinal tract are considered, melanoma, cancer of the lung and breast cancers are the commonest primary tumors that metastasize to the gastrointestinal tract.3

Occult bleeding from duodenal metastases from cancer of the lung has been reported4 and on occasion these have bled from a superior mesenteric artery-duodenal fistula.7 Frank bleeding from the metastatic deposits in the duodenum, as was evident in this patient, has been rarely reported.8 In that report active bleeding had stopped and therefore no endoscopic intervention was performed.

There is a report of successful pancreaticoduodenectomy for metastatic small cell cancer of the lung.2 The metastases was at the ampullary area. We are not aware of any report where metastatic deposit from squamous cell cancer of the lung led to obstruction of the biliary ductal system as well as the duodenum.

References

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Endoscopic band ligation for non variceal bleed

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Endoscopic band ligation (EBL) is an infrequently used modality for treatment of non-variceal hemorrhage. We report the successful use of this technique for the management of bleed from blue rubber bleb nevus syndrome lesions and post polypectomy bleeding stalk. [Indian J Gastroenterol2004;23:186-187]

Key words: Blue rubber bleb nevus syndrome, rectal polyp

Endoscopic band ligation (EBL) has recently been used for the treatment of non variceal bleed. Blue rubber bleb nevus syndrome and post polypectomy bleeding stalk have been conventionally treated with surgery or modalities like argon plasma coagulation,


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**Leino-renal collaterals causing left pelviureteric junction obstruction**

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Pelviureteric junction obstruction of the kidneys secondary to crossing renal vessels is a known entity. We report a 26-year-old woman with obstruction secondary to portosystemic collaterals; she was incidentally detected to have extrahepatic portal vein obstruction. [Indian J Gastroenterol 2004;23:187-188]

**Key words:** Portal hypertension

Pelviureteric junction (PUJ) obstruction can be due to intrinsic or extrinsic causes. Obstruction secondary to crossing renal vessels has been reported earlier.1 A 26-year-old woman presented with pain in the left loin since 6 months. Ultrasonography revealed left hydronephrosis secondary to PUJ obstruction. The right kidney was normal. Splenomegaly was noted with multiple perisplenic collaterals. The left lobe of liver was hypoplastic with multiple small collaterals in the portal vein region (portal cavernous). Intravenous urography showed normal right kidney and ureter. Gross left-sided hydronephrosis was noted with double bubble sign, that is, filling of the renal pelvis and the proximal segment of ureter stuck to it without filling of the ureter distal to it. This sign is suspicious of crossing renal vessels, hence the patient was referred for CT angiography.

CT angiography showed normal renal arteries. The left kidney showed gross hydronephrosis with thin parenchyma. Multiple collaterals were seen in the region of the portal vein with no definite portal vein. The left lobe of liver was hypoplastic, with calcific foci in the liver and spleen, along with splenomegaly and multiple perisplenic collaterals. The splenic...