the most common hematological toxicities (Table). Nausea and vomiting were rare and were mild.

**Table: Hematological adverse effects as per Eastern Cooperative Oncology Group criteria**

<table>
<thead>
<tr>
<th>Toxicity grades</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Nil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>2</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Leukopenia</td>
<td>0</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>Nil</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>Nil</td>
<td></td>
</tr>
</tbody>
</table>

Values are of number of patients
Grades: 0 (none), 1 (mild), 2 (moderate), 3 (severe), 4 (life-threatening)

Complete radiological response occurred in two patients (12%) and partial response in eight (47%). Five patients had static disease and in two patients the disease progressed. Patients with liver metastasis responded better than those with lymph node metastasis – both the complete responders and four of eight partial responders had liver metastasis. Median time to disease progression from the time of surgery or from date of detection of metastasis was 10.5 months (range, 8 to 14) and median survival was 14.5 months (range, 11 to 26).

The results we obtained are encouraging. In an EORTC trial, mitomycin-C alone produced objective response in only three of 30 patients with advanced gall bladder and biliary tract cancers. In another trial cisplatin was administered at a dose of 80 mg/m² every four weeks in previously untreated patients with unresectable biliary tract carcinoma; only 8% showed partial response lasting for only three months. Four patients with unresectable and/or metastatic gall bladder cancer showed no response when treated with intravenous paclitaxel 170 mg/m² every three weeks. Similarly, three patients received intravenous gemcitabine 1000 mg/m² weekly for at least eight courses but no objective response could be demonstrated.

Because of the disappointing results with monotherapy, various combination regimes have been tried. In a randomized phase II trial, the Eastern Cooperative Oncology Group compared oral 5-FU monotherapy with oral 5-FU and either intravenous streptozotocin or intravenous lomustine in 53 patients with gall bladder carcinoma. The overall response rate was less than 10%, with no evidence that the combined therapy was superior to the monotherapy in terms of response rate or survival. After non-curative resection of adenocarcinoma of gall bladder, Kato et al treated 16 patients with mitomycin-C, 5-FU and oral Tegafur for 4 weeks. Similar seven patients received weekly 5-FU infusion and intravenous leucovorin for six weeks. The median survival was 230 days and 471 days in the two groups, respectively.

In conclusion, despite various chemotherapeutic combinations, response rates of more than 30% in advanced gall bladder cancer have been difficult to achieve. The result of this trial suggests that weekly 5-FU and leucovorin combination is an effective regimen for metastatic gall bladder cancer. The protocol is well tolerated; toxicities are mostly hematological and easily manageable. The chemotherapy was delivered on out-patient basis and is cheap.

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**References**


**Endoscopic management of bleeding ectopic varices due to extrahepatic portal vein obstruction**

Bleeding from ectopic varices is uncommon. Of 332 patients with extrahepatic portal vein obstruction on regular follow up, five patients (1.5%) had bleeding from ectopic varices. Four patients presented with hematemesis and one had hematochezia. The mean hemoglobin on admission was 6.3 (1.3) g/dL. Liver profile and other blood tests were normal. These patients were stabilized with blood transfusion and three patients received octreotide infusion also. Endoscopy revealed bleeding duodenal varix in three
patients, isolated gastric varix in one patient, and bleeding from rectal varices in the fifth patient.

In the first patient, bleeding from duodenal varix was controlled by injection of 12 mL of 1.5% sodium tetracel sulphate (STD). Endoscopy after one month showed reduction in the size of duodenal varix, and one more session of sclerotherapy using 4 mL of STD was given. During the subsequent 14-year follow up, there was no recurrence of esophageal or duodenal varices. The second patient with bleeding duodenal varix (Fig.) was treated with 8 mL of 1.5% STD. There was no recurrence of bleeding during the next four years. In the third patient, duodenal variceal bleeding was controlled with variceal ligation using the Wilson Cook ligating device. There was no recurrence of bleeding during a follow up of one year. All these patients had esophageal varices eradicated earlier; ectopic varices appeared after a mean period of 3.3 years (range, 1-5.5).

The fourth patient had isolated tortuous bluish vessels with a bleeding point in the lesser curvature of the stomach at the junction of antrum and body (IGV2 type). Bleeding was controlled with injection of one mL of cyanoacrylate. There was no further bleeding during the next one year. The fifth patient who presented with hematochezia had large rectal varices at colonoscopy. Upper GI endoscopy was normal. Bleeding was successfully controlled with injection of 6 mL 2% polidocanol. There was no recurrence of bleeding during the next six months.

There is no consensus regarding the management of bleeding from ectopic varices. After hemodynamic stabilization and administration of vasoconstrictors, the treatment options include injection sclerotherapy, variceal ligation, duodenal resection, TIPS and portacaval shunt. There are some reports of successful therapy of duodenal varices with injection sclerotherapy, injection of N-butyl-2-cyanoacrylate and endoscopic ligation. There are isolated reports of management of bleeding rectal varices by sclerotherapy and variceal band ligation.

In conclusion, bleeding ectopic varices that are endoscopically accessible can be treated successfully by endotherapy along with the use of vasoactive drugs.

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References

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Gastric fluid level after overnight fast: test to diagnose gastric outlet obstruction in corrosive esophageal stricture

Corrosive injuries of the esophagus, particularly due to acids, are often associated with concomitant gastric injury in the form of pre-pyloric stricture. However, because of the esophageal obstruction it is difficult to confirm gastric outlet obstruction either by endoscopy or barium contrast study. Since these patients have high-grade dysphagia, a succussion splash due to gastric stasis is rarely elicited.

In such patients we have found that an erect abdominal film after overnight fasting shows a gastric fluid level in the presence of gastric outlet obstruction (Fig). This observation has been consistently noted by us and confirmed at surgery in all such patients. None of the patients without gastric