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 tetradecyl 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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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

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outlet obstruction had such a fluid level.

We advocate this procedure as a simple tool to diagnose gastric outlet obstruction in the presence of esophageal obstruction due to corrosive injury. Identification of gastric outlet obstruction prior to surgery has important therapeutic implications.

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Asymptomatic gallstone: what are its functional characteristics?

Mohandas and Patil1 state that "preventive cholecystectomy be offered to all young healthy women in northern India when they are diagnosed to have asymptomatic gallstones." Kapoor2 outlines six situations that may qualify for such a drastic measure. Is the label 'healthy' appropriate for women with gallstones? Does the incidence of cancer differ between symptomatic and asymptomatic patients with gallstones?

Currently a patient with gallstone and suspected biliary pain is labeled as 'symptomatic'. We propose that gall bladder ejection fraction (GBEF) is a more objective and reproducible parameter for determining disease.3 We routinely measure GBEF with cholecystokinin (CCK) in all patients suspected of biliary pain. Post-CCK pain with low EF is labeled biliary in origin, and pain with normal EF as non-biliary. About 30% of patients (unpublished data) with gallstones have normal EF and many of these are followed by watchful waiting.4 Most patients with low EF are subjected to laparoscopic cholecystectomy, with relief of pain in more than 90%.5

We suggest that the six indications outlined by Kapoor2 can be replaced by an objective parameter like GBEF.

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Cecal web causing neonatal intestinal obstruction

Cecal web is a rare entity, presenting in adults as a mass lesion or space-occupying lesion.1,2 We are not aware of any report of cecal web presenting as acute intestinal obstruction in a neonate.

A 2-day-old full-term male baby weighing 2.8 Kg was admitted with history of no passage of meconium since birth, associated with abdominal distension and bilious vomiting. His mother’s antenatal history was uneventful, and the neonate was born of normal vaginal delivery. Physical examination revealed diffuse abdominal distension with visible bowel loops. The neonate was dehydrated. On rectal examination there were mucus pellets only. Serum electrolytes were normal; X-ray abdomen showed multiple air-fluid levels.

After stabilizing the neonate, we explored his abdomen through right supra-umbilical incision. Findings at surgery were a thick, edematous cecum, with patchy gangrenous changes, dilated ileum and micro-colon from ascending colon onwards. An intraluminal mass, 2 cm × 2 cm, was palpable at the junction of the cecum and ascending colon. Cecotomy revealed a thick-walled complete membrane between the cecum and ascending colon with small central opening (Fig). The cecum and adjoining ileum and ascending colon were resected and ileum was anastomosed to ascending colon. Biopsy revealed ectopic gastric mucosa of fundic type containing mainly chief and parietal cells.