A rare cause of haematemesis – 'downhill varices'

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Introduction

Oesophageal varices are a well-known cause of upper gastrointestinal (GI) bleed. However, proximal oesophageal varices, also known as 'downhill varices', account for about 0.1% of all cases of variceal haemorrhage.[1]

Case report

A 57-year-old male, a known case of chronic kidney disease, post-renal transplant (which was done 3 months ago), presented with significant haematemesis. He was hypotensive and had a tachycardia of 140 beats per minute on presentation. He was immediately started on intravenous fluids while his relevant blood tests were sent. On detailed history, it was revealed that prior to the transplant he was on haemodialysis via an internal jugular vein dialysis catheter which was removed in the preoperative period. One month post-surgery he had developed facial swelling and was found to have thrombi in his bilateral jugular veins and superior vena cava (SVC). He was started on anticoagulants (low-molecular-weight heparin and warfarin) and was monitored regularly. In view of raised international normalised ratios (INRs) and his history, it was initially suspected that the bleeding was secondary to anticoagulants. In view of low haemoglobin, and an episode of melaena in the emergency room (ER) itself, the patient was transfused two units of packed red blood cells. The gastroenterology team was consulted in view of ongoing haematemesis and advised for an urgent upper GI endoscopy (UGIE). Meanwhile the patient was shifted to the intensive care unit for further monitoring.

Results and discussion

An urgent UGIE was done which showed multiple large varices in the proximal oesophagus. It was seen that there was an active bleed from one of the varices at 30 cm from the incisors for which endoscopic band ligation was done to control the bleeding.

Over the next 24 hours the patient gradually started improving and there were no further episodes of haematemesis or melaena.

Any obstruction in SVC or the jugular veins will interfere with drainage of the upper and middle oesophagus. Thus, eventually leading to formation of collaterals which may extend even distally depending on the level and duration of obstruction.[2,3]

SVC obstruction is most commonly caused by compression from mediastinal malignancy, which accounts for 60% of cases as reported in literature.[4] However, in our case, the cause turned out to be completely benign which was not associated with any external compression.

Conclusion

Interestingly, as per literature, in 30% of patients with SVC obstruction downhill varices are seen on screening UGIE.[1]

Screening UGIE should be considered in patients who are on anticoagulants for SVC thrombus as there is additional risk of bleeding. Not much is known regarding pharmacological management of downhill varices unlike varices in the distal part of the oesophagus. Hence recanalising SVC wherever possible must be carried out as a priority. This case report also testifies the usefulness of UGIE in not only diagnosis but also in management of variceal bleed in the upper oesophagus. ■

Conflict of interest statement

None declared.

References

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