Journal of Chemical Health Risks

www.jchr.org

JCHR (2024) 14(3), 3010-3011 | ISSN:2251-6727

Extrahepatic Portal Vein Obstruction in a Cirrhotic Paient- A Case Report

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(Received: 04 February 2024 Revised: 11 March 2024 Accepted: 08 April 2024)

KEYWORDS
Extrahepatic,
Vein Obstruction

ABSTRACT:

EHPVO can present as early as 6 weeks after birth and also manifest in adulthood. The most common clinical feature is hematemesis[1] . Patients can present with melaena from oesophageal gastric varices and also bleed from ectopic varices or bleeding from the biliary tract. Anaemia, splenomegaly are other common features of EHPVO and hypersplenism also seen in few patients. Ascites is seen more in adult patients with liver disease. Jaundice may result from bile duct compression because of dilated venous collaterals due to portal biliopathy. Frequency of cholelithiasis is more in EHPVO.

Introduction

EHPVO can present as early as 6 weeks after birth and also manifest in adulthood. The most common clinical feature is hematemesis[1] . Patients can present with melaena from oesophageal gastric varices and also bleed from ectopic varices or bleeding from the biliary tract. Anaemia, splenomegaly are other common features of EHPVO and hypersplenism also seen in few patients. Ascites is seen more in adult patients with liver disease. Jaundice may result from bile duct compression because of dilated venous collaterals due to portal biliopathy. Frequency of cholelithiasis is more in EHPVO.[2]

Case History

A 40year old female patient presented with recurrent hematemesis, melaena, abdominal distension and generalized tiredness since 1 week. She was diagnosed as DCLD with portal HTN & esophageal varices for which banding was done in 2015. Investigations showed pancytopenia. USG Abdomen showed massive splenomegaly with collaterals, hepatomegaly, ascites and cystitis. Diagnostic ascitic tapping done. ECHO showed Normal study. Based on the investigations, a diagnosis of EHPVO was made. Treated with appropriate antibiotics, diuretics, beta blockers and PPI's. In view of obtaining surgical gastroenterologist opinion and further management, she has been referred to higher center.

Discussion

Her chief symptoms were hematemesis and melaena. She had similar complaints 7 years back and was diagnosed

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as DCLD with portal HTN and oesophageal variceal banding was done. Since then she was on T. Lasilactone 50mg 2 OD and T. Propranolol 40mg 2 OD. On admission, Hb was 6.6g%, TC- 1800 and platelet count 32000. Ascitic fluid cytology showed inflammatory smear. USG Abdomen showed massive splenomegaly, hepatomegaly, ascites, liver coarse in echotexture with mid surface nodularity, portal vein completely replaced by collaterals and cystitis. CT Thorax showed no active pulmonary infection but ascites, splenomegaly, attenuated portal veins, collaterals in left gastric, perihilar and splenic hilar regions were seen. PRBC and FFP was given. Treated with antibiotics, diuretics, beta blockers etc. She has been referred to higher center in view of obtaining surgical gastroenterologist opinion and for further management.

Conclusion

In adults, EHPVO is usually diagnosed accidentally when evaluating for other disorders or with rare presentations such as jaundice, ascites etc. The portal vein in EHPVO is transformed into a cavernoma, which is a bunch of multiple collateral veins around the obstructed portion of portal vein. Adults are more prone for EHPVO due to hypercoagulability, local inflammation, intra-abdominal sepsis, myeloproliferative disorders, underlying cirrhosis, or malignancies in the liver, bile ducts or pancreas.[3,4,5,6] Recent improvement in the management of variceal bleeding in patients with EHPVO have led to a better survival. For primary prophylaxis of variceal bleeding, there is no enough data on whether beta-blocker or endoscopic therapy should be preferred. For control of acute variceal bleed, endoscopic therapy is effective. For secondary prophylaxis, beta-blockers are as effective as EVL. Decompressive surgery or interventional radiological treatment should be considered for patients with failure of endoscopic therapy.

References:

1. Chawla Y, Dilawari JB, Katariya S. Gallbladder varices in portal vein thrombosis. AJR Am J Roentgenol. 1994;162:643–5. [PubMed]
2. Bhatia V, Jain AK, Sarin SK. Choledocholithiasis associated with portal biliopathy in patients with extrahepatic portal vein obstruction: Management with endoscopic sphincterotomy Gastrointest Endosc. 1995;42:178–81 [PubMed] [Google Scholar]
3. Valla D - C, Condat B, Lebrec D. Spectrum of portal vein thrombosis in the West. J Gastroenterol Hepatol 200217S224–S227. [PubMed] [Google Scholar]
4. Amitrano L, Brancaccio V, Guardascione M A.et al Inherited coagulation disorders in cirrhotic patients with portal vein thrombosis. Hepatology 200031345–348. PubMed] [Google Scholar]Sarin S K, Agarwal S R. Extrahepatic portal vein obstruction. Semin Liver Dis 20022243–58. [PubMed] [Google Scholar]
5. Condat B, Pessione F, Denninger M H.et al Recent portal or mesenteric venous thrombosis: increased recognition and frequent recannalization on anticoagulation
6. Therapy. Hepatology 200032466–470.[PubMed] [Google Scholar]