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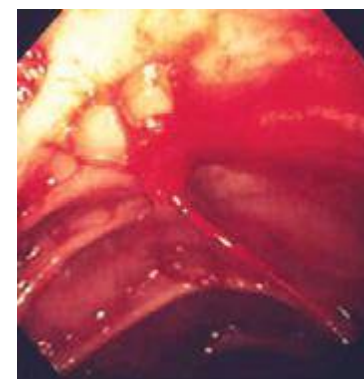
B

FIGURE 345-25 Gastric varices. **A.** Large gastric fundal varices. **B.** Stigmata of recent bleeding from the same gastric varices (arrow).

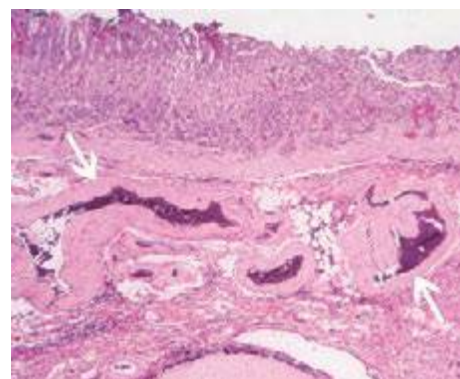
varices are the only identifiable cause of acute hemorrhage. Bleeding from large gastric fundic varices (Fig. 345-25) is best treated with endoscopic cyanoacrylate (“glue”) injection (see Video 346e-10), because EVL or EVS of these varices is associated with a high rebleeding rate. Complications of cyanoacrylate injection include infection and glue embolization to other organs, such as the lungs, brain, and spleen.

After treatment of the acute hemorrhage, an elective course of endoscopic therapy can be undertaken with the goal of eradicating esophageal varices and preventing rebleeding months to years later. However, this chronic therapy is less successful, preventing long-term rebleeding in ~50% of patients. Pharmacologic therapies that decrease portal pressure have similar efficacy, and the two modalities may be combined.

Dieulafoy’s Lesion This lesion, also called *persistent caliber artery*, is a large-caliber arteriole that runs immediately beneath the gastrointestinal mucosa and bleeds through a pinpoint mucosal erosion (Fig. 345-26). Dieulafoy’s lesion is seen most commonly on the lesser curvature of the proximal stomach, causes impressive arterial hemorrhage, and may be difficult to diagnose; it is often recognized only after repeated endoscopy for recurrent bleeding. Endoscopic therapy, such as thermal coagulation or band ligation, is typically effective for control of bleeding and ablation of the underlying vessel once the lesion has been identified (see Video 346e-11). Rescue therapies, such as angiographic embolization or surgical oversewing, are considered in situations where endoscopic therapy has failed.



A



B

FIGURE 345-26 Dieulafoy’s lesion. **A.** Actively spurting jejunal Dieulafoy’s lesion. There is no underlying mucosal lesion. **B.** Histology of a gastric Dieulafoy’s lesion. A persistent caliber artery (arrows) is present in the gastric submucosa, immediately beneath the mucosa.

Mallory-Weiss Tear A Mallory-Weiss tear is a linear mucosal rent near or across the gastroesophageal junction that is often associated with retching or vomiting (Fig. 345-27). When the tear disrupts a submucosal arteriole, brisk hemorrhage may result. Endoscopy is the best method of diagnosis, and an actively bleeding tear can be treated endoscopically with epinephrine injection, coaptive coagulation, band ligation, or hemoclips (see Video 346e-12). Unlike peptic ulcer, a Mallory-Weiss tear with a nonbleeding sentinel clot in its base rarely rebleeds and thus does not necessitate endoscopic therapy.

Vascular Ectasias Vascular ectasias are flat mucosal vascular anomalies that are best diagnosed by endoscopy. They usually cause slow intestinal blood loss and occur either in a sporadic fashion or in a well-defined pattern of distribution (e.g., gastric antral vascular ectasia [GAVE] or “watermelon stomach”) (Fig. 345-28). Cecal vascular ectasias, GAVE, and radiation-induced rectal ectasias are often responsive to local endoscopic ablative therapy, such as argon plasma coagulation (see Video 346e-13). Patients with diffuse small-bowel vascular ectasias (associated with chronic renal failure and with hereditary hemorrhagic telangiectasia) may continue to bleed despite endoscopic treatment of easily accessible lesions by conventional endoscopy. These patients may benefit from deep enteroscopy with endoscopic therapy, pharmacologic treatment with octreotide or estrogen/progesterone therapy, or intraoperative enteroscopy.

Colonic Diverticula Diverticula form where nutrient arteries penetrate the muscular wall of the colon en route to the colonic mucosa (Fig. 345-29). The artery found in the base of a diverticulum may bleed, causing painless and impressive hematochezia. Colonoscopy is indicated in patients with hematochezia and suspected diverticular hemorrhage, because other causes of bleeding (such as vascular ectasias, colitis, and colon cancer) must be excluded. In addition, an actively bleeding diverticulum may be seen and treated during colonoscopy (Fig. 345-30, see Video 346e-14).

GASTROINTESTINAL OBSTRUCTION AND PSEUDOObSTRUCTION

Endoscopy is useful for evaluation and treatment of some forms of gastrointestinal obstruction. An important exception is small-bowel obstruction due to surgical adhesions, which is generally not diagnosed or treated endoscopically. Esophageal, gastroduodenal, and colonic obstruction or pseudoobstruction can all be diagnosed and often managed endoscopically.

Acute Esophageal Obstruction

Esophageal obstruction by impacted food (Fig. 345-31) or an ingested foreign body is a potentially life-threatening event and represents an endoscopic emergency. Left untreated, the patient may develop esophageal ulceration, ischemia, and perforation. Patients with persistent esophageal obstruction often have hypersalivation and are usually