

Esophageal Varices: A Case Study

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ABSTRACT

Esophageal varices incidences are increasing by nearly 5% every year. Esophageal varices are the causes of bleeding in approximately 18% of hospital admissions for upper GI bleeding.

Objective: The purpose of this study is to understand the cause, clinical manifestations and treatment course for esophageal varices.

Material and methods: Detailed clinical history and physical examination was done. All the pertinent investigations were studied thoroughly of the selected case.

Results: The esophageal varices is confirmed with the help of upper gastrointestinal gastroscopy and repaired by banding.

Conclusion: Esophageal varices usually go undiagnosed due to early common symptoms. Hematemesis is one of the suggestive of esophageal varices and OGD is only the confirmative diagnosis for it. The prognosis depends usually better if treatment received on time.

INTRODUCTION

Esophageal varices are abnormal, enlarged veins in the tube that connects the throat and stomach. Variceal rupture is governed by Laplace's law. Increased wall tension is the end result of increased intravariceal pressure, increased diameter of the varices and reduced wall thickness. The variceal wall thickness can be evaluated visually by the presence of red wale markings. These markings reflect areas where the wall is especially thin [1]. Variceal rupture often occurs at the level of the gastroesophageal junction, where the varices are very superficial and thus have thinner walls. Esophageal varices are the major complication of portal hypertension [2].

RISK FACTORS

- Large esophageal varices
- Red marks on the esophageal varices as seen on a lighted stomach scope (endoscopy)
- Portal hypertension
- Severe cirrhosis
- A bacterial infection
- Excessive alcohol use
- Excessive vomiting
- Constipation
- Severe coughing bouts

DIAGNOSTIC INVESTIGATIONS

- Blood tests
- Endoscopy
- Imaging tests, such as CT and MRI scans

ESOPHAGEAL VARICES SYMPTOMS

- Hematemesis
- Stomach pain
- Light-headedness or loss of consciousness
- Melena (black stools)
- Bloody stools (in severe cases)
- Shock (excessively low blood pressure due to blood loss that can lead to multiple organ damage)

TREATMENT

Therapeutic approaches are variceal ligation (banding) and sclerotherapy. Banding is a medical procedure which uses elastic bands for constriction. Banding may be used to tie off blood vessels in order to stop bleeding, as in the treatment of

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bleeding esophageal varices. The band restricts blood flow to the ligated tissue, so that it eventually dies and sloughs away from the supporting tissue.

Sclerotherapy is a form of treatment where a doctor injects medicine into blood vessels or lymph vessels that causes them to shrink. It is commonly used to treat varicose veins or so-called spider veins. The procedure is non-surgical, requiring only an injection.

CASE STUDY

An 85 year old patient with known case of diabetes mellitus, hypertension since last 20 years and status post percutaneous transluminal coronary (2002, 2011 and 2015). Patient had no history of any bad habits like cigarette smoking, alcohol consumption or any other drug substance. Patient was found semiconscious at home at night suddenly and when aroused by relatives, patient had hematemesis of around 500 ml at home. Patient was brought to hospital. The patient had complaints of malena and acidity since one week. Patient was investigated in the form of alkaline phosphatase, alpha fetoprotein, serum glutamic pyruvic transaminase, SGOT, bilirubin, glucose, IgG, CBC, USG KUB, ABG, Electrocardiogram, APTT, ESR, USG whole abdomen.

CBC shows Hb less than 7 g/dl. USG whole abdomen was suggestive of reduced size of liver with diffusely altered echo texture and surface irregularity, suggestive of chronic liver parenchymal disease. Few small tortuous mesenteric venous collaterals, could be suggestive of portal hypertension.

Upper gastrointestinal gastroscopy was suggestive of esophageal varices. One band applied endoscopically and further, patient was managed with anti-diabetics, antacid, analgesic, antibiotic, beta blocker, statin and other supportive care.

CONCLUSION

Esophageal varices usually go undiagnosed until hematemesis occur. Hematemesis is a medical emergency and always occur due to upper GI tract bleeding. The color is usually bright red in color. The hematemesis is treated with somatostatin analogue (e.g. Octreotide) or vasopressin (e.g. Terlipressin); it helps to reduce splanchnic blood flow. The Glasgow-Blatch Ford Bleeding scoring system score is used to determine the risk. This scale is purely based on clinical and biochemical parameters. The warning signs of esophageal varices is dizziness even when awake, weight loss, low Hb level, complaints of acidity, heartburn, hematemesis and malena.

Patients with hypertension and diabetes have poor prognosis as medicines have adverse effects on liver which can lead to liver cirrhosis and portal hypertension as well. At advanced age, the banding is done for symptomatic treatment only as no other option is available at this age.

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