A case of cerebral and splenic infarctions after Histocaryl injection in esophageal varix bleeding

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Variceal bleeding is the most serious complication of portal hypertension and accounts for about one fifth to one third of all deaths in liver cirrhosis patients. In variceal bleeding, endoscopic options for treatment include variceal ligation and injection sclerotherapy. Although injection sclerotherapy with various sclerosants including N-butyl-2-cyanoacrylate provides effective treatment for variceal bleeding, injection sclerotherapy is associated with a variety of complications, some of which can be disastrous. A 55-year-old woman with alcohol-induced liver cirrhosis, who presented with hematemesis was hospitalized. Endoscopic finding showed large esophageal varices with active bleeding. Because of large esophageal varices, injection sclerotherapy with N-butyl-2-cyanoacrylate was applied. Variceal bleeding was controlled. However, she developed dysarthria and right hemiparesis at 1 hr after injection sclerotherapy. Brain computed tomography (CT) and magnetic resonance imaging (MRI) showed acute multifocal cortical infarctions in both frontal, and parietooccipital lobes and left cerebellar hemisphere. Abdominal CT revealed that splenic infarction was seen. To evaluate cause of cerebral and splenic infarctions, transcranial doppler and bubble test was performed. In this test, the ultrasound waves are reflected by even the smallest bubbles and are detected by the probe. It means that she had a patent foramen ovale. Embolism by N-butyl-2-cyanoacrylate became the cause of cerebral and splenic infarctions via patent foramen ovale. Cerebral and splenic infarctions, despite its rarity, should be considered in the serious complications of injection sclerotherapy with N-butyl-2-cyanoacrylate.

Intrahepatic hemorrhage in a patient with antiphospholipid antibody syndrome

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The antiphospholipid antibody syndrome (APS) is characterized by venous or arterial thrombosis, or pregnancy morbidity in the presence of antiphospholipid antibodies (aPL). Therefore, the main therapy is based on the long-term anticoagulation in patients with APS. These anticoagulation therapy may be associated with a significant risk of bleeding complications. Gastrointestinal bleeding was most common complication and renal hemorrhage, hemorrhagic corpus luteum and alveolar hemorrhage were rarely reported. We report a woman with primary APS who had intraparenchymal hemorrhagic complication in the liver during anticoagulation treatment and such a condition has not been previously described in APS. A 18-year-old woman was diagnosed primary APS and received long-term warfarin therapy due to recurrent deep vein thrombosis. A six years later, She developed right flank pain and abdominal Computed tomography (CT) scanning showed the low attenuated lesion in S2/4 and S5 segment of liver. We diagnosed intraparenchymal hemorrhage in the liver. After stopped oral anticoagulation, Subsequent CT scan showed regression of the hemorrhage. We agonized the restart of warfarin and decided to start clopidogrel instead of warfarin. Since then, the patient has not developed any recurrent thrombotic episodes or bleeding complications.