

usually patients recover with supportive therapy. This can be prevented by creating awareness in those areas where this practice is prevalent.

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A Salvage for Upper Gastro Intestinal Bleeding: Better Use of Existing Resources

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Upper Gastrointestinal (UGI) Bleeding is a common medical emergency. Variceal bleeding accounts for nearly 15% of all UGI Bleeds.¹ It is sometimes torrential and associated with high morbidity and mortality with

reported rates varying from 10-20%.² Combination therapy with vasoactive drugs (within 30 min of hospitalization) and endoscopic variceal ligation (door to scope time within 12 hrs of admission) is the current standard of care.³ Resource poor places have limited availability to both. Many cases in such situations have adverse outcome because of delayed availability of proper medical care and failure of initial hemostasis. We herewith present a case where a novel use of widely available medical equipment averted a crisis.

Case Report

Forty two year male, chronic alcohol consumer, a known case of cirrhosis with portal hypertension, had Child A status and small esophageal varices. He was lost to follow up after initial work up. He presented to us one morning with history of recurrent hematemesis, malena and giddiness. He was started on Intravenous Somatostatin, antibiotics and IV fluids and Ryle's Tube (RT) aspirations. He was planned for Endoscopy after initial stabilization. He continued to bleed, his sensorium worsened and his blood pressure was dropping despite doubling the dose of Somatostatin. We had no Intensive care back up and Sangestaken Blakemore (SB) Tube was not available. His condition and rapid progression of events were not allowing for a transfer to a better equipped place.

We modified the RT by tightly securing a Latex condom at the end it (above the proximal feeding holes). A leak test was performed by filling the condom with 300 ml of water outside. After insertion up to 60 cms, we instilled 100 ml of water through the RT, 50 ml of air was then pushed and gush was heard in left hypochondriac region, to ensure position in to the stomach. It was filled further with 200 ml of water and a gentle pull back was done till resistance was felt. Tube position was marked at this place with a tape and was secured at the nostril with the help of Needle cap and tapes.

Bleeding stopped immediately, hemodynamic parameters started improving. He was transfused one unit of packed blood. We deflated the system after 12 hrs and took him up for do upper Gastro Intestinal Endoscopy. He had four columns of small varices with red colour signs

and fibrin plug on one of the varices. Esophageal variceal ligation (EVL) could be done uneventfully. He was on oral feeds after 6 hrs, was continued on somatostatin for 4 more days. Rest of his hospital stay was uneventful without further need of blood. Malena cleared after 3 days and he was discharged on D6 on non selective Beta Blockers and Hematinics. Subsequently he remained on endoscopic and clinical follow ups. Varices could be obliterated after 2 subsequent EVL sessions. He did well till 3 years when he restarted alcohol succumbed to hepatic decompensation.

Discussion

Gastrointestinal Bleed is a common medical emergency, despite improvement in medical care and endoscopic practices mortality remains high. Judicious blood transfusion, antibiotic use, early vasoactive drugs and better endoscopic techniques have modified the management of variceal bleed significantly. Endoscopy should be offered to all patients of variceal bleed after resuscitation within 12 hours of presentation.² This should be followed by follow up endoscopy and B Blocker dose adjustment and care as applied for status of liver dysfunction. The real world experience is different and recent surveys from developed places had shown that only 62% of services were able to provide a formalized rota of endoscopy specialists round the clock and only 56% can offer acute admissions an endoscopy within 24 hours of admission.⁴

The situation is worse in underdeveloped places. Referral to a capable medical center after immediate resuscitation is the mainstay of management at such places. Standard of care at most of such places is resuscitation, supportive and pharmacological therapy which stabilises the patient in most of the cases and then transfer for detailed assessment of the etiology and specific therapy reduce the risk of rebleed.

A subset of patients with persistent bleed despite resuscitation and pharmacotherapy needs urgent referral. Ongoing bleed during transit leads to hemodynamic instability and shock which becomes a major deterrent to urgent institution of definitive therapy. Another important



Figure 1: The equipment – Ryles tube with latex condom.



Figure 2: Ready assembly – Leak testing.

complication is aspirations in to lungs during transit particularly if the patient develops altered sensorium due to liver disease or hypotension. These added complications become the major determinant of outcome in such patients in addition to the baseline disease.

Ideally patients with UGI and altered sensorium should be intubated to prevent aspiration in to lungs. SB tube should be placed to tamponade varices till definitive therapy could be instituted.² The major limitation to this approach is limited availability of the equipment and training particularly at peripheral health set ups.⁵

As demonstrated in our case RT with condom tied at its distal end may be a useful equipment in cases of uncontrolled GI bleeds because of its widespread availability and easy insertion technique. It provides tamponade in variceal bleeds and may also reduce the risk of aspirations as it occludes the Gastro Esophageal

Junction. Another important use of this device can be in the management of uncontrolled fundal variceal bleeds as emergency salvage till TIPS or surgery. Linton's tube ideally indicated in such cases is again limited by its availability. As condom on further inflation balloons up and can store more than 2 liters of fluid. This property can be utilised to tamponade Fundal varices and varices of rest of the stomach.

The method requires standardisation and validation in larger groups but has promise particularly in a resource poor place with limited availability of advanced medical care. Our experience, though small offered salvage to a patient who might have succumbed while being referred or waiting for surgery.

Conclusion

Status of patient at presentation is an important determinant of outcome. Ryle's tube and condoms are widely available, cheap and requires little training for placement. It's use can reduce significant morbidity and mortality especially in resource poor places.

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Acute Pancreatitis due to Dengue: Report of an Uncommon Complication and Literature Review

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Dengue is a mosquito-borne viral infection which is endemic in tropical and subtropical countries. Reports of dengue fever (DF) and dengue hemorrhagic fever (DHF) presenting with atypical manifestations due to hepatic, renal, cardiac or nervous system involvement (expanded dengue syndrome) are available in literature.^{1,2} Acute pancreatitis is a very infrequently reported complication of DF and the published literature is in the form of case report or small case series.³⁻²⁰ We report a case of acute pancreatitis complicating dengue fever and review the published literature on acute pancreatitis related to dengue and its course and outcomes.

Case Report

A 32 years old male patient presented with sudden onset severe epigastric pain with radiation to back lasting for six days. Pain abdomen was associated with 2-3 episodes of vomiting at the onset. Subsequently he developed abdominal distension and decreased bowel movements. Four days prior to the onset of pain abdomen patient had developed high grade fever with rigor which was associated with malaise, bodyache and headache. Patient denied any co-morbidities or any history of trauma. Patient was treated conservatively by a local physician