

Study courtesy of:  
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## HISTORY

A 55 year old gentleman with end stage liver disease due to hepatitis C cirrhosis presented with acute upper GI bleeding manifested by hematemesis, melena, and syncopal episode. On physical examination, he was tachycardic, hypotensive, and encephalopathic. A nasogastric tube lavage revealed fresh blood and clots which did not clear after two liters of tap water lavage. After resuscitation with blood products (packed red blood cells, fresh frozen plasma and platelets), the patient was started on intravenous octreotide and endotracheally intubated for airway protection prior to endoscopy.

## PROCEDURE

Endoscopy revealed active bleeding from an esophageal varix in the distal esophagus as well as two additional non-bleeding variceal columns (see Figure 1). Endoscopic variceal ligation was performed for acute hemostasis of the bleeding varix (see Figure 2). Five additional bands were placed on adjacent, non-bleeding varices in the distal esophagus to prevent variceal rebleeding. The clear band alerts the endoscopist that one band is left on the device (see Figure 3).

The Wilson-Cook Multi-Band Ligation Device (Saeed Six-Shooter) was used because of its ease of loading, reliable band release mechanism, enhanced endoscopic view, and ability to perform injection sclerotherapy with the banding device in place in the event of refractory bleeding.

## OUTCOME

The enhanced view allowed for accurate band placement over the bleeding point (see Figure 2). Active bleeding was controlled with one band placed directly on the bleeding varix; the remaining five bands were placed on adjacent, non-bleeding varices in the distal esophagus for variceal obliteration. Two additional banding treatment sessions, performed at monthly intervals, resulted in complete variceal eradication (see Figure 4). The patient underwent successful liver transplantation 8 months later without rebleeding in the interim.

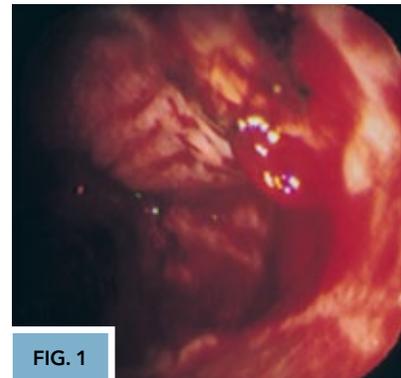


FIG. 1

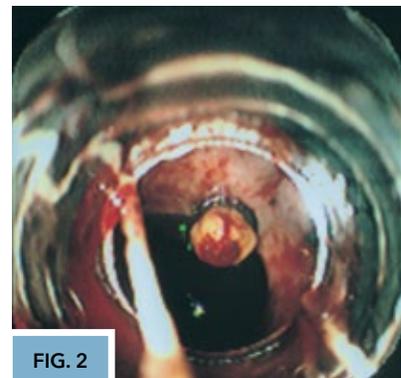


FIG. 2

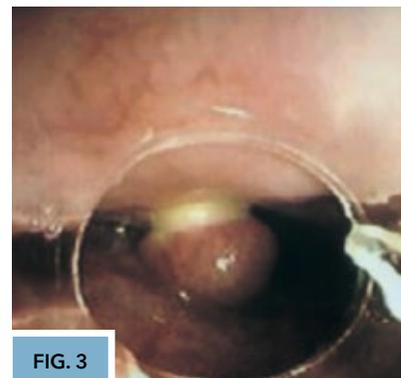


FIG. 3

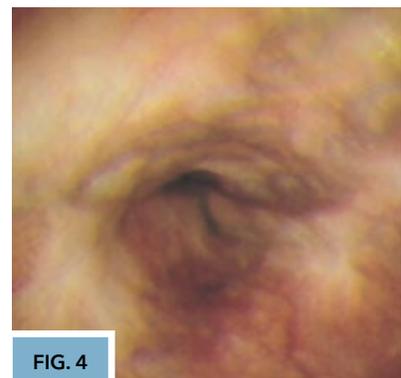


FIG. 4

**COOK ENDOSCOPY**  
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