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CASE REPORT

Beyond Cirrhosis: When Pancreas Bleed

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ABSTRACT

Pancreatic cancer is a highly aggressive malignancy with poor prognosis, largely due to its silent onset and delayed diagnosis. Patients typically present with vague symptoms such as abdominal discomfort, jaundice, anorexia, and weight loss. Uncommonly, pancreatic malignancy may initially manifest as upper gastrointestinal bleeding, a presentation that can obscure the underlying diagnosis. One rare but important mechanism for such bleeding is splenic vein thrombosis, which leads to left-sided portal hypertension and the development of isolated gastric varices. Unlike portal hypertension due to chronic liver disease, this condition spares the liver and oesophagus, making recognition challenging. In the emergency setting, patients presenting with melena or hematemesis in the absence of liver dysfunction, ascites, or abnormal liver function tests often prompt diagnostic uncertainty. Cross-sectional imaging with contrast-enhanced CT or MRI plays a crucial role in identifying splenic vein thrombosis and associated pancreatic pathology. Tumours involving the pancreatic tail are particularly prone to causing venous compression or invasion, resulting in thrombosis. Management differs from conventional variceal bleeding, as endoscopic therapy provides only temporary control. Definitive treatment requires addressing the underlying cause, often through distal pancreatectomy with splenectomy in resectable disease. This report highlights pancreatic cancer as a rare but critical cause of isolated gastric variceal bleeding and emphasizes the importance of maintaining a high index of suspicion to enable timely diagnosis and potentially curative intervention.

KEYWORDS

• Cirrhosis • Pancreatic cancer • Gastric varices • Variceal bleed

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INTRODUCTION

Pancreatic cancer is the seventh leading cause of cancer-related deaths worldwide, with pancreatic ductal adenocarcinoma (PDAC) accounting for approximately 90% of cases.[1] The disease often presents insidiously, with symptoms such as abdominal discomfort, weight loss, and jaundice. Due to its deep anatomical location and the nonspecific nature of early symptoms, pancreatic cancer is frequently diagnosed at an advanced stage, contributing to its poor prognosis.[2]

Upper gastrointestinal (GI) bleeding is a common emergency, typically resulting from peptic ulcers, oesophageal varices, or gastric erosions. However, pancreatic cancer presenting as upper GI bleeding is exceedingly rare, reported in only 2-3% of cases. When it does occur, the bleeding is often due to tumour invasion into adjacent vascular structures or the development of left-sided portal hypertension secondary to splenic vein thrombosis.[3]

Left-sided portal hypertension, also known as sinistral portal hypertension, arises from isolated splenic vein thrombosis, leading to increased pressure in the short gastric and gastroepiploic veins. This condition can result in the formation of isolated gastric varices, which are prone to bleeding. Unlike generalized portal hypertension, left-sided portal hypertension does not typically present with oesophageal varices or ascites, making diagnosis more challenging.

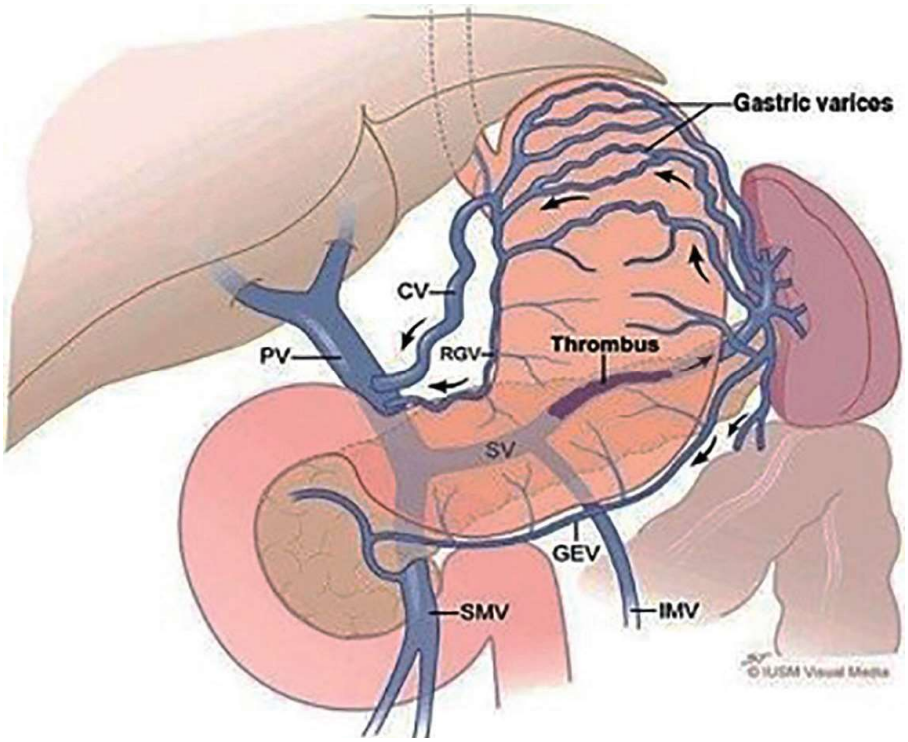


Image Source: Google Search Engine, Netter's Atlas of Anatomy

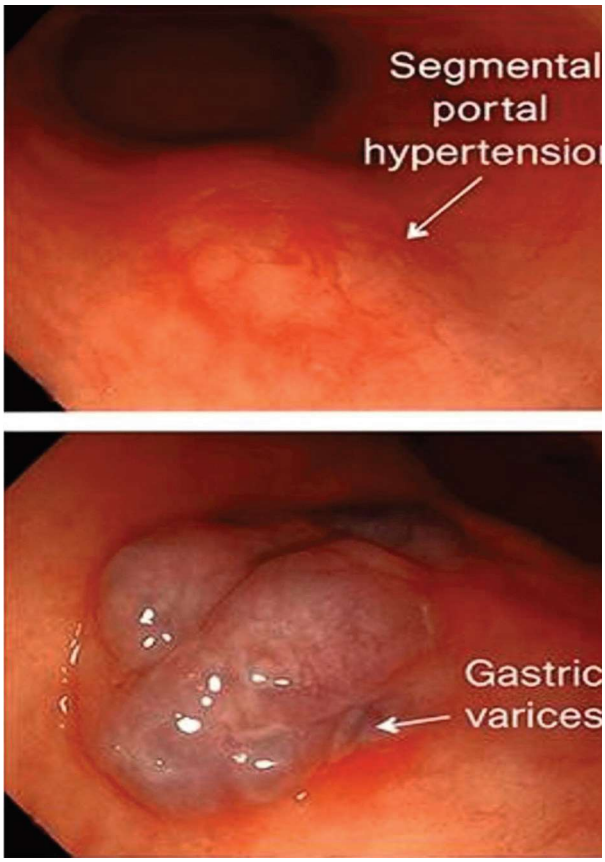
In this report, we present a case of pancreatic tail adenocarcinoma manifesting as upper GI bleeding due to splenic vein thrombosis and isolated gastric varices.[4] We aim to highlight the diagnostic challenges and the importance of considering pancreatic pathology in atypical presentations of GI bleeding.[5]

CASE

A 64-year-old female brought to the emergency department with complaints of black, tarry stools for three days and generalized weakness. She denied any abdominal pain, nausea, vomiting, or weight loss. There was no history of liver disease, alcohol use, or use of nonsteroidal anti-inflammatory drugs.

On examination in the emergency department, the patient was alert and oriented. His initial vital signs in the ED: heart rate 118 beats per minute, blood pressure 90/40 mmHg, respiratory rate 18 breaths per minute, oxygen saturation 98% on room

air, temperature 36.7°C. The primary survey for the patient was not significant (ABCDE). Abdominal examination was unremarkable, with no tenderness, organomegaly, or ascites. Rectal examination confirmed melena. Patient was provisionally diagnosed as a case of upper GI bleed. Patient was immediately planned for upper GI endoscopy.



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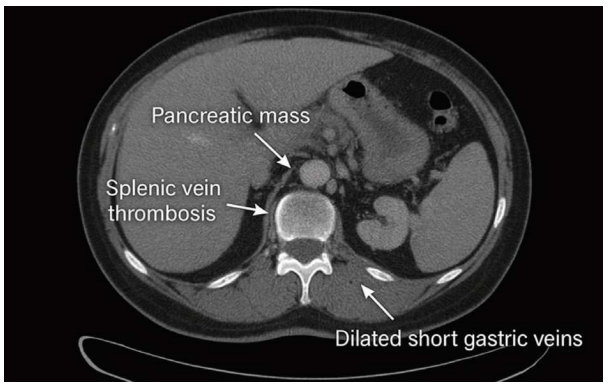
Upper GI endoscopy which showed isolated gastric varices in the fundus without any oesophageal varices or active bleeding source.



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Given the absence of liver disease and the presence of isolated gastric varices, a contrast-enhanced computed tomography (CT) scan of the abdomen was obtained. The CT scan revealed a 4 cm mass in the pancreatic tail causing compression and thrombosis of the splenic vein. There was evidence of collateral circulation with dilated short gastric veins, consistent with left-sided portal hypertension.

The patient was stabilized with blood transfusions and supportive care and was admitted under multidisciplinary care under oncology team and gastroenterology team in the management. Given the localized nature of the tumour and the absence of distant metastases, the patient underwent a distal pancreatectomy with splenectomy.

After 12 days of admission, postoperative recovery was uneventful. Histopathological examination confirmed moderately differentiated pancreatic ductal adenocarcinoma with negative margins and no lymph node involvement. The patient is under medical oncology for adjuvant chemotherapy and is currently under regular follow-up with no signs of recurrence.

DISCUSSION

Pancreatic cancer is notorious for its late presentation and poor prognosis. While common symptoms include abdominal pain, weight loss, and jaundice, atypical presentations can occur, complicating timely diagnosis.[1] One such rare presentation is upper GI bleeding due to isolated gastric varices resulting from splenic vein thrombosis.

The splenic vein runs posterior to the pancreas and is susceptible to compression or invasion by pancreatic tumours, especially those located in the tail. Obstruction of the splenic vein leads to increased pressure in the short gastric and gastroepiploic veins, culminating in the formation of isolated gastric varices.[2] Unlike generalized portal hypertension, this condition does not affect the portal vein or liver, and patients typically lack signs such as oesophageal varices or ascites.

Diagnosing left-sided portal hypertension requires a high index of suspicion, especially in patients presenting with gastric variceal bleeding without underlying liver disease.[3] Imaging modalities like contrast-enhanced CT or magnetic resonance imaging (MRI) are instrumental in identifying splenic vein thrombosis and associated pancreatic pathology.

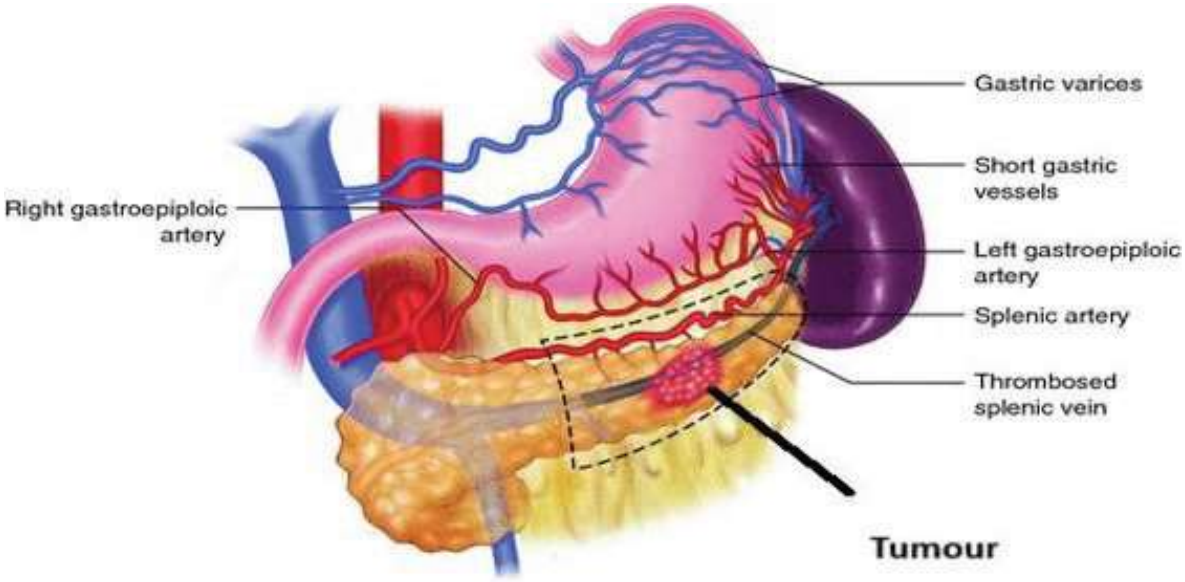

Image Source: Google Search Engine

Management of bleeding gastric varices in this context involves addressing both the variceal bleeding and the underlying cause. Endoscopic interventions, suchk as cyanoacrylate injection, can control acute bleeding. However, definitive treatment often necessitates surgical intervention, including splenectomy and resection of the pancreatic tumour.[4]

This case emphasizes the importance of considering pancreatic cancer in the differential diagnosis of upper GI bleeding, particularly when isolated gastric varices are identified without evidence of liver disease.[5] Early recognition and appropriate management can significantly impact patient outcomes.

CONCLUSION

Pancreatic cancer can present atypically as upper gastrointestinal bleeding due to splenic vein thrombosis and isolated gastric varices. Clinicians should maintain a high index of suspicion for pancreatic pathology in patients with gastric variceal bleeding without cirrhosis. Prompt imaging and multidisciplinary management are essential for accurate diagnosis and effective treatment, potentially improving patient prognosis.

REFERENCES

1. Obleaga C.V., Vere C.C., Mogoanta S.S., *et al*. Upper Gastrointestinal Bleeding - Initial Manifestation of Pancreatic Head Carcinoma. *Curr Health Sci J*. 2017; 43(3): 236-240.
2. Victor D.W. III, Nguyen K., Zhang D.S., *et al*. Massive Gastric Variceal Hemorrhage Due to Splenic Vein Thrombosis: A Rare Initial Presentation of Asymptomatic Metastatic Pancreatic Adenocarcinoma. *J Liver Res Disord Ther*. 2018; 4(3): 121-122.
3. McDermott V.G., England R.E., Newman G.E. Bleeding Gastric Varices Secondary to Splenic Vein Thrombosis Successfully Treated by Splenic Artery Embolization. *Br J Radiol*. 1995; 68(812): 928-930.
4. Sutton J.M., *et al*. Gastric Varices Secondary to Splenic Vein Occlusion Due to Pancreatic Diseases. *J Gastrointest Cancer*. 2012; 43(1): 1-4.
5. Thavanathan J., Heughan C., Cummings T.M. Splenic Vein Thrombosis as a Cause of Variceal Bleeding. *Can J Surg*. 1992; 35(6): 649-652.