Letter to the Editor

An unsolved case of gastric outlet obstruction
B S Bhaviya¹ , Sudheer Mohammed², Avik Bhattacharyya³, Sumit Gulati², Supriyo Ghatak²

¹Department of General Surgery, Calcutta Medical Research Institute
²Department of Surgical Gastroenterology, Calcutta Medical Research Institute,
³Department of interventional radiology, Calcutta Medical Research Institute

Gastric Outlet Obstruction (GOO) implies complete or incomplete obstruction of the distal stomach, pylorus or proximal duodenum [1]. This may occur due to an obstructing luminal mass lesion, external compression or as a result of obstruction from acute edema, chronic scarring and fibrosis or a combination of both [1,2]. The major cause of gastric outlet obstruction in this era of proton pump inhibitors is malignancy. Here we present an unusual case of gastric outlet obstruction which revealed features of malignancy on imaging and the lesion regressed with nutritional improvement of the patient.

A 65 year man presented to us on September 2014 with GOO. He had complaints of anorexia, weight loss for past 2 months and was cachectic tolerating only liquid diet. He was diabetic for past 10 years with no other co morbidities. Upper gastrointestinal endoscopy (UGIE) showed extensive circumferential ulceronodular friable lesion from mid body to antrum. Distensibility was decreased in the affected areas with plenty of hemorrhagic fluid with undigested food material seen in the stomach. Biopsy from the lesion showed acute on chronic gastritis. Contrast enhanced computed tomography (CECT) scan of whole abdomen revealed irregular circumferential mural thickening involving predominantly the body and antral region of stomach with a large mass noted in the distal stomach with gastric outlet obstruction. There was infiltration of perigastric fat and loss of fat planes between stomach and body, tail of pancreas and left lobe of liver.

As the CECT and UGIE findings suggested irresectable malignancy we decided to improve the nutritional status of the patient along with a repeat biopsy for tissue diagnosis. We inserted a fluoroscopy guided nasojejunal tube for feeding. But, three successive endoscopic biopsies did not yield any definite diagnosis. CT guided FNAC was tried, but it was inconclusive. Left with no alternative we decided for a diagnostic laparoscopy in the hope of getting some tissue for diagnosis. After 6 weeks of starting nasojejunal feeding he was admitted for surgery. A repeat CECT scan of abdomen revealed similar findings as before. At this time his appetite was improved a little with marginal increase of serum albumin (2.4 gm/dl to 2.8 gm/dl). During diagnostic laparoscopy we found a thickened antrum & distal body of stomach which was surprisingly mobile and separate from the pancreas and the liver. There were no peritoneal deposits or ascites. We performed a subtotal gastrectomy with gastrojejunostomy and feeding jejunostomy. The resected specimen revealed a thickening of antral and distal body of stomach wall with an inflamed red mucosa at the antrum. Histopathology showed chronic gastric ulcer with superimposed candidiasis and fibrosis of stomach wall with hypertrophy of muscular layer with dense lymphoplasmacytic infiltrate and lymphoid nodules. There were 14 lymph nodes all of which were reactive. Retrospectively when we looked back at all the endoscopic pictures, it seemed there was some regression of the lesion on the mucosal aspect over time.

Diseases causing GOO can be benign and malignant. Historically GOO has been considered a disease process synonymous with chronic peptic ulcer disease. However since the advent of proton pump inhibitors, the complications from peptic ulcer disease have drastically decreased with a change in ratio between benign and malignant gastric outlet obstruction [3,4]. The major benign causes of gastric outlet obstruction (GOO) are peptic ulcer disease, gastric polyps, ingestion of caustics, pyloric stenosis, congenital duodenal webs, gallstone obstruction (Bouveret syndrome), pancreatic pseudocysts, and bezoars [5,6]. Other tumours that may obstruct the gastric outlet include ampullary cancer, duodenal cancer, cholangiocarcinomas, gastric cancer and metastases. Most patients with GOO present with vomiting as their cardinal symptom and tend to develop dehydration and dys electrolytemia if untreated. Malnutrition and weight loss are frequent when the condition approaches chronicity and are most significant in patients with malignant aetiologies.

Our patient had initially presented with features of irresectable gastric malignancy on CECT with multiple inconclusive biopsy reports. Later on with nutritional support he had showed an improvement in the general clinical condition. The final histopathology of specimen had revealed chronic gastric ulcer with superimposed candidiasis and fibrosis of stomach wall.

Candida infection in the stomach can present as ulcerations or plaques and may cause stenotic change when developed in regions such as distal antrum, pylorus, or duodenal bulb [7-10]. Candida infected ulcers may also mimic metastatic gastric cancers radiologically. In our case candidiasis was pre-
sent only in few areas of the lesion and the lesion was more like a superimposed candidiasis than candida induced ulcer.

Gastric outlet obstruction is the most common presentation of gastric tuberculosis which may mimic malignancy at clinical presentation and can be misleading. Although gastric tuberculosis was one of our differential diagnosis initially, due to the lack of features of gastric tuberculosis like caseating granulomas in the specimen this differential diagnosis was subsequently ruled out.

There are many more mimickers of gastric malignancies like gastric lymphoma, Kaposis sarcoma, gastric lipoma, gastric polyps, GIST and gastric carcinoids of which only lymphoma are self-regressing. Mucosa associated lymphoid tissue (MALT) lymphoma is a type of primary gastric lymphoma which can have atypical presentations including gastric outlet obstruction and can mimic advanced gastric carcinomas radiologically with multiple inconclusive endoscopic biopsies. MALT lymphomas has been found to have association with H pylori and they regress with eradication of H Pylori with antibiotics. A previous case report describes an unusual presentation of MALT lymphoma which clinically presented like an advanced gastric carcinoma. In our case the patient had shown improvement with adequate nutrition with no other medications and the tests for H pylori were negative.

In conclusion we report an unusual case of gastric outlet obstruction which clinically presented like an advanced gastric carcinoma and regressed on its own with the improvement of nutritional status of the patient.

References

Corresponding author
Supriyo Ghatak, MBBS, MS, MCh
Consultant,
Department of Surgical Gastroenterology,
Calcutta Medical Research Institute,
7/2 Diamond Harbour Road, Kolkata 700027, India
drsupriyo@yahoo.co.in
+919874138687