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Case Report

A rare cause of gastric outlet obstruction: gastric polyp

Nadir bir mide çıkış tıkanıklığı nedeni: mide polipi

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ABSTRACT

Gastric outlet obstruction is a clinical syndrome characterized by epigastric abdominal pain due to mechanical occlusion and postprandial vomiting. An 82-year-old male patient applied to the emergency service with nausea, vomiting and abdominal pain. The patient with amylase elevation was admitted with pre-diagnosis of acute pancreatitis. However, pancreas parenchyma was normal in abdominal CT. A giant gastric polyp causing gastric outlet obstruction was detected in endoscopy which was decided after duodenal wall thickening. Tubular adenoma with high grade dysplasia was detected in biopsy. Here, we aim to present a case of gastric polyp that can rarely cause gastric outlet obstruction.

Keywords: gastric outlet obstruction, gastric polyp, endoscopy

ÖZ

Gastrik çıkış obstrüksiyonu, mekanik tıkanıklığa bağlı epigastrik karın ağrısı ve postprandiyal kusma ile karakterize klinik bir sendromdur. Seksen iki yaşında erkek hasta bulantı, kusma ve karın ağrısı ile acil servise başvurdu. Amilaz yüksekliği saptanan hasta akut pankreatit ön tanısı ile yatırıldı. Ancak abdomen tomografisinde pankreas parankimi normal saptandı. Duodenumda duvar kalınlaşması saptanması üzerine planlanan endoskopisinde gastrik çıkış obstrüksiyonuna sebep olan dev gastrik polip saptandı. Biyopsi sonucu high grade displazi içeren tubuler adenoma olarak saptandı. Burada gastrik çıkış obstrüksiyonuna nadiren sebep olabilen gastrik polip olgusunu sunmayı amaçladık.

Anahtar kelimeler: mide çıkış tıkanıklığı, gastrik polip, endoskopi

INTRODUCTION

Gastric outlet obstruction (GOO) is a clinical syndrome that appears through nausea, epigastric pain and vomiting because of some mechanical causes. However, it is not a fully known incidence. Parallel to the success in the recent treatment of the peptic ulcer, the frequency of GOO has declined. It is reported that approximately 2000 operations were performed for GOO in the United States, in 1990 [1].

Gastric outlet obstruction is a misleading term because most of the cases are not related to isolated gastric pathology, but duodenal or extraluminal diseases are generally the reasons for it. With the determination of Helicobacter pylori and the use of proton pump inhibitors, the most important causes have changed significantly. Benign disease was known to be responsible for the majority of GOO cases in adults until the 1970s but it composed between 10% and 39% of malignant cases only [2-4]. However, in recent years, between 50% and 80% of the cases occur secondary to malignancy [2,4-6].

It is generally incidental to detect the gastric polyps at endoscopy. The detection is reported to be about 5% [7]. Gastric polyps are usually known to be asymptomatic, but gastrointestinal bleeding or rarely, obstruction can be included among the clinical features [8].

CASE REPORT

An 82-year-old male patient was admitted to the emergency room with abdominal pain, nausea and vomiting. In anamnesis, it was found out that his epigastric complaints were long lasting. He applied to the emergency service due to the increase in pain in addition to nausea, vomiting complaints. In the examinations in emergency service, it was seen that the patient had amylase elevation and he was hospitalized with pre-diagnosis of acute pancreatitis.

Except for epigastric tenderness, systemic examination was normal on physical examination. No pathology was detected apart from amylase 920 U / L and urea 56 mg / dl in laboratory tests. Duodenal wall thickening was detected in contrast-enhanced abdominal tomography (**Figure 1**). Then, endoscopy was planned for the patient. A gastric fold was observed in upper GI endoscopy extending from stomach corpus to the pylorus and making pyloric passage hard to pass through (**Figure 2**). While attempting to pass through the pylorus with endoscope, a giant polyp (6-7 cm in diameter) originating from the corpus was seen prolapsing into the pylorus (**Figure 3**). It was seen that peduncular polyp resulted from the corpus. A polypoid lesion was observed on the opposite wall of this polyp as mucosal swelling. The process was ended conducting a biopsy on both polyps. Tubular adenoma with high grade dysplasia was reported in biopsy. It was suggested that polyp should be taken surgically due to the fact that it was too big to be removed from oesophagus. The symptoms improved in the patient's clinical follow-up. The patient could tolerate oral intake and he did not have any clinical complaints, so he was discharged.

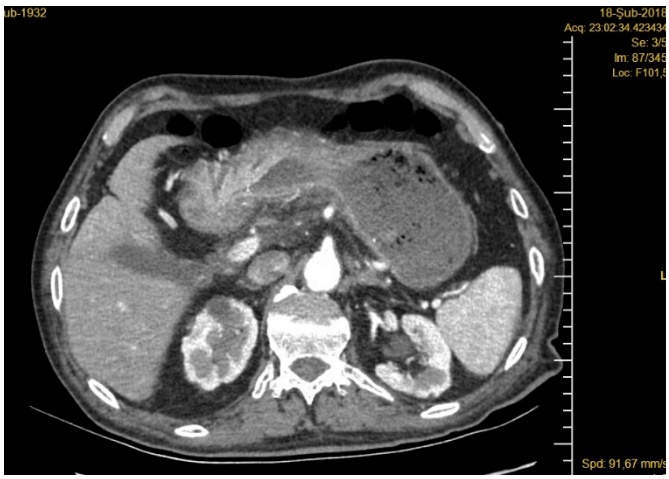

Figure 1. Duodenal wall thickening in abdominal CT

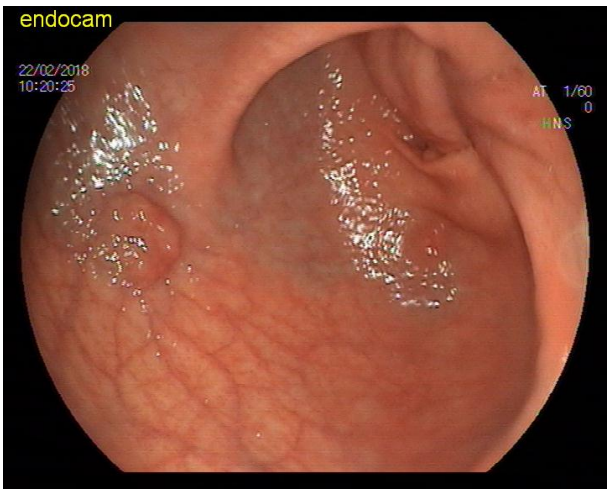

Figure 2. Gastric fold extending to pylorus in endoscopy

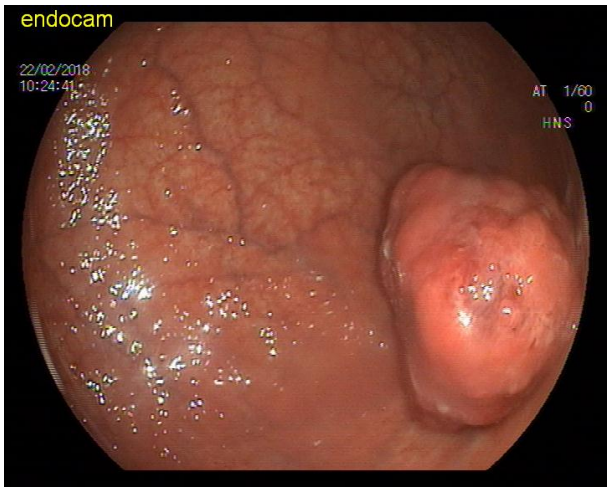

Figure 3. Giant polyp originating from the corpus and prolapsing into the pylorus

CONCLUSION

Gastric polyps are usually asymptomatic and randomly diagnosed during endoscopic examinations. Depending on their size and localization, they may cause non-specific symptoms such as anaemia of iron deficiency, abdominal pain, dyspeptic symptoms, intestinal obstruction, weight loss and rarely massive digestive haemorrhage [9]. Polyps cases due to the anatomical area near the pylorus have been reported [10].

It has recently been reported from Turkey in a case originating from the fundus [11].

In our case, we encountered gastric outlet obstruction mimicking acute pancreatitis due to typical symptoms and amylase elevation. Endoscopy was decided because of the fact that the pancreas was normal in the abdominal tomography of the patient and a thickening was detected on duodenal wall. We aimed to present this case since the image detected in endoscopy was interesting and gastric polyps caused gastric outlet obstruction extending to pylorus rarely.

DECLARATION OF CONFLICT OF INTEREST

The author declared no conflicts of interest with respect to the authorship and/or publication of this article.

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