REFRACTORY PEPTIC ULCER DISEASE CAUSING GASTRIC OUTLET OBSTRUCTION

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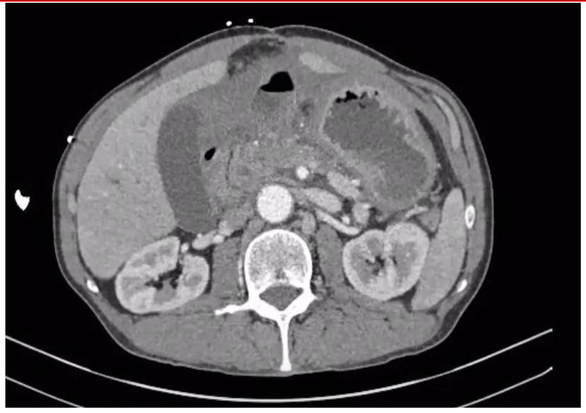
INTRODUCTION

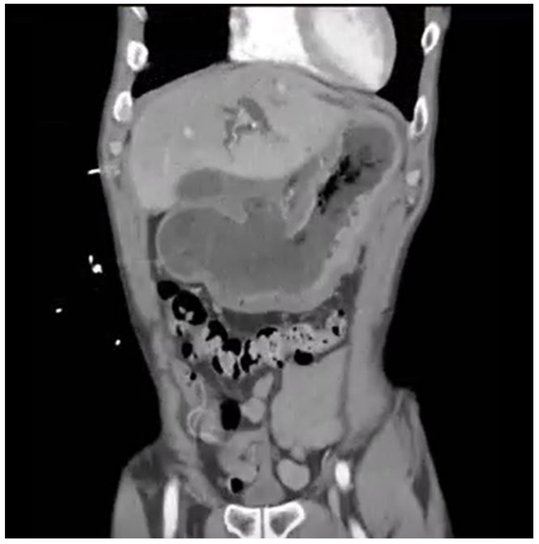
Peptic ulcer disease is most commonly due to excessive NSAID use and H. pylori infection. If left untreated, it can progress to bleeding, perforation, and in rare cases gastric outlet obstruction[1]. With the introduction of PPI's and antibiotic treatment for H. pylori, the clinical course of peptic ulcer disease has changed tremendously[1]. Although PPI's remain the mainstay of treatment, refractory peptic ulcer disease can lead to chronic complications that are difficult to identify and result in adverse patient outcomes when missed. Herein we discuss a case of gastric outlet obstruction in a 65-year-old man with refractory peptic ulcer disease, with a clinical course that has only been described once previously.

CASE SCENARIO

A 65-year-old man with a history of PUD complicated by posterior gastric ulcer perforation status post graham patch repair four years ago presented with intractable epigastric abdominal pain, nausea, and vomiting. Despite being compliant with omeprazole, the patient reported that for the last year he had poor oral tolerance and frequent emesis of food particles.

Recent EGD showed a large antral ulcer and pyloric stenosis with possible pancreatic head mass versus stricture. A biopsy of the antral ulcer was negative for malignancy. Endoscopic ultrasound was unsuccessful due to the pyloric stenosis. CEA, CA 19-9 and AFP were within normal limits. Although no mass was seen on CT, severe gastric distention with GOO was present on imaging, therefore the decision was made to proceed with operative intervention to relieve the obstruction.





Preoperative CT CAP with IV contrast:

Ill-defined pancreatic head with extrinsic compression of the gastroduodenal artery. Gastric antrum thickening with transition point in the area of the pylorus with thinning of the posterior antrum. Intrahepatic and extrahepatic biliary ductal dilatation.

CASE SCENARIO CONT'D

Intraoperatively, the pancreatic head was fused to the pylorus and antrum, and therefore not amenable to separation for antrectomy. The decision was made to bypass the obstruction with a gastrojejunostomy. Furthermore, no mass was noted on palpation, rather the obstruction appeared all secondary to inflammatory changes. Given the severe adhesions and inflammatory changes, no tissue specimen was able to be sent to pathology.

CONCLUSION

Refractory peptic ulcer disease causing gastric outlet obstruction due to severe inflammatory changes is a very rare complication of the disease. As the clinical symptoms and workup can mimic malignancy, a thorough history and broad differential diagnosis are key to identifying the disease etiology to guide treatment.

REFERENCES

Robert T. Kavitt, Anna M. Lipowska, Adjoa Anyane-Yeboa, Ian M. Gralnek, Diagnosis and Treatment of Peptic Ulcer Disease, The American Journal of Medicine, Volume 132, Issue 4, 2019, Pages 447-456,ISSN 0002-9343