

INTRODUCTION

Adult idiopathic hypertrophic pyloric stenosis remains an infrequently encountered diagnosis, with current literature describing only 200-300 documented cases [1]. Only one prior case of gastric remnant outlet obstruction from pyloric stenosis after Roux-en-Y gastric bypass (RYGB) has been reported [2]. Its rarity, combined with clinical features that overlap with more prevalent causes of outlet obstruction, such as peptic ulcer, often leads to diagnostic ambiguity [3].

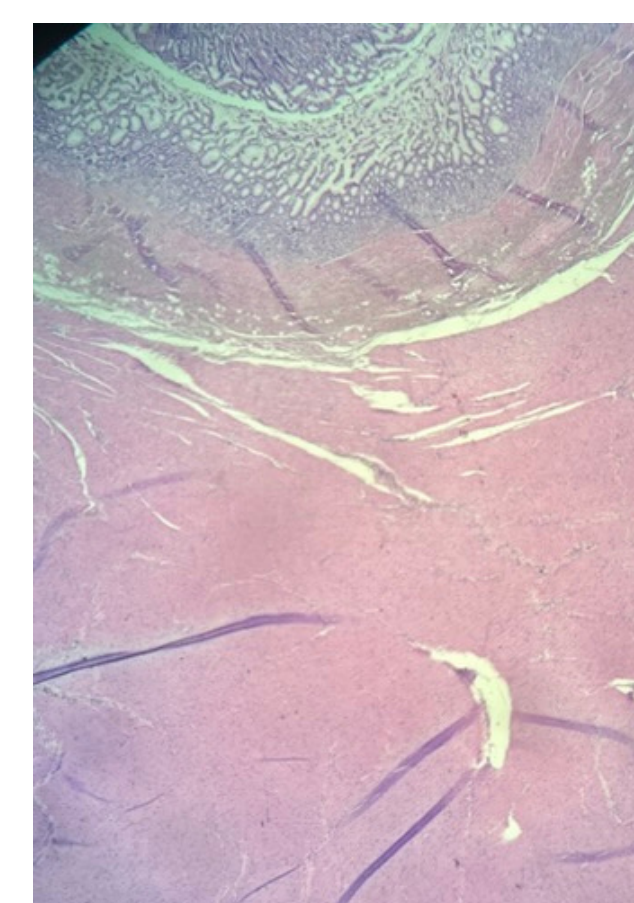
CASE PRESENTATION

A 68-year-old woman with a history of RYGB 20 years prior.

- **Initial presentation:** Nausea, vomiting, early satiety, 11-lb weight loss
- **Initial imaging:** CT concerning for antral remnant mass; esophagram normal Roux anatomy
- **Transgastric endoscopic evaluation** due to RYGB anatomy: Congested pylorus; biopsies benign
- **Two years later → recurrence:** Abdominal pain, nausea/vomiting, 64-lb weight loss
- **Repeat imaging:** Marked dilation of excluded gastric remnant with circumferential pyloric thickening → gastric outlet obstruction

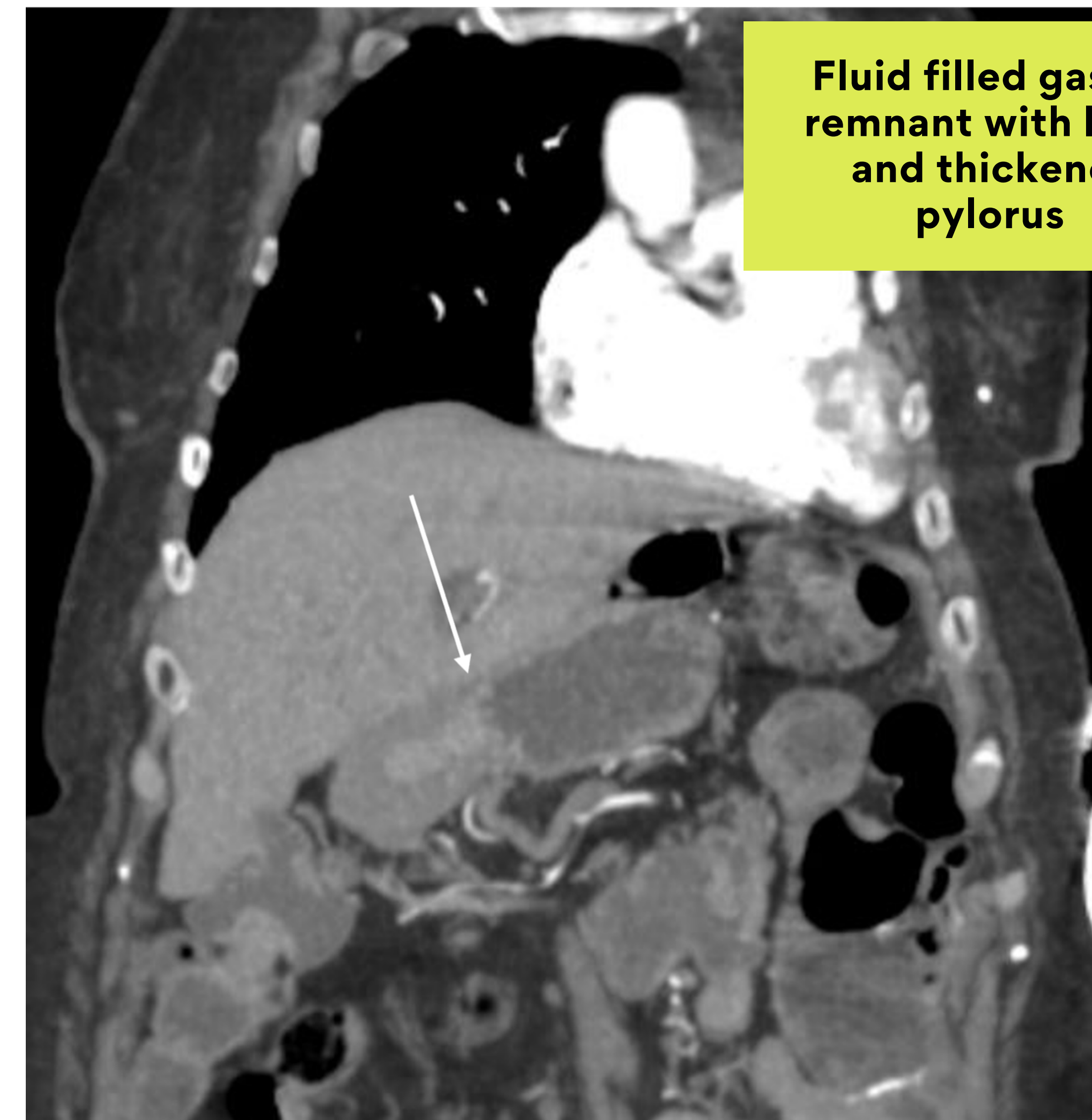
The patient elected to proceed with robotic-assisted remnant gastrectomy. Intraoperatively, the excluded stomach was markedly distended with significant pyloric thickening, without mucosal lesions or extrinsic compression, and the Roux limb and gastrojejunal anastomosis were intact.

Pathology demonstrated 5.3-cm hypertrophy of the pyloric musculature, and histologic evaluation confirmed hypertrophic pyloric stenosis without malignancy. →

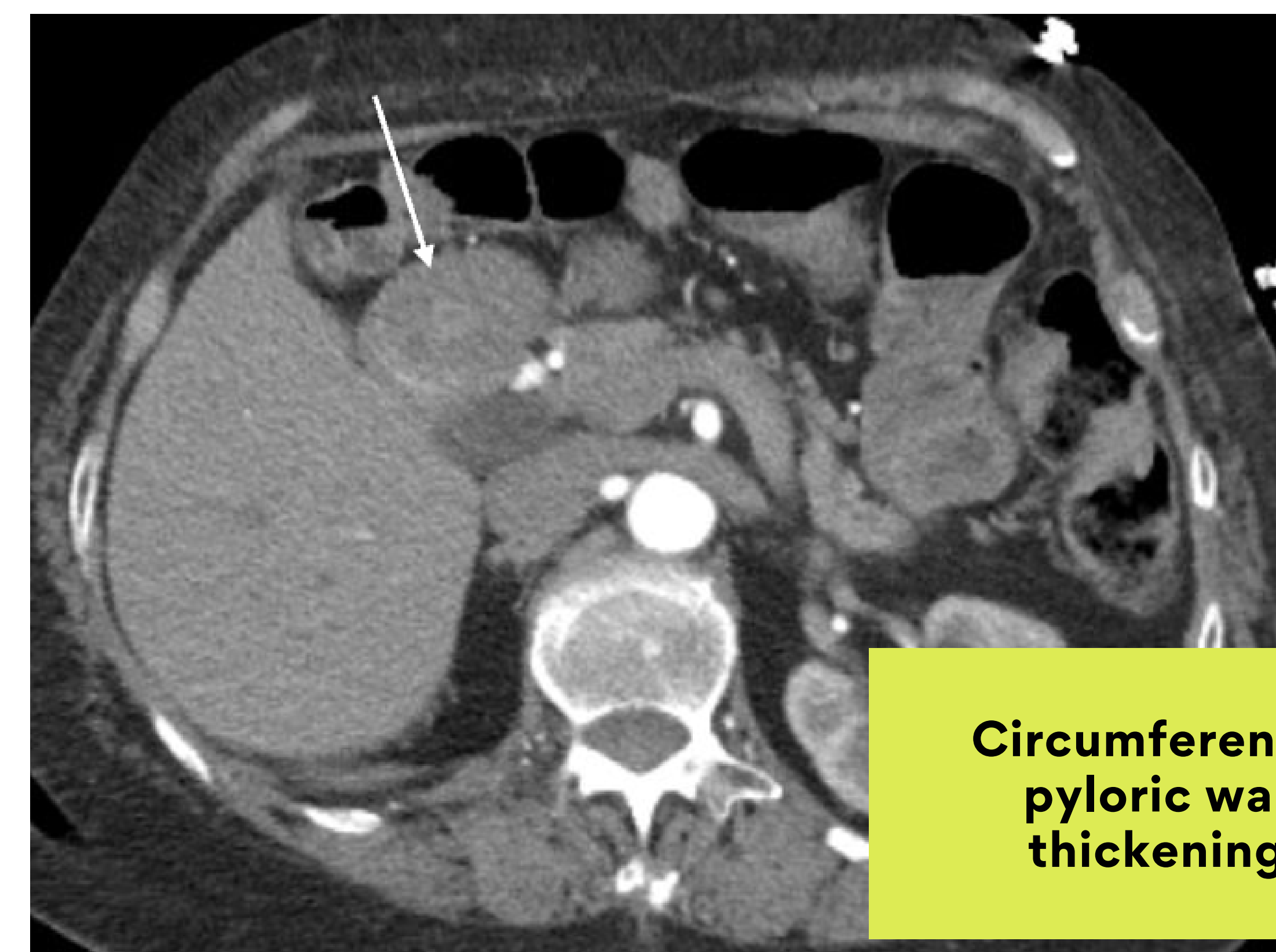


The patient was discharged on postoperative day five and reported complete resolution of symptoms at follow-up.

IMAGES



Fluid filled gastric remnant with large and thickened pylorus



Circumferential pyloric wall thickening

KEY OPERATIVE STEPS

Adhesiolysis and mobilization of the gastric remnant with careful preservation of the Roux limb mesentery; omentum divided to enter the lesser sac and expose the posterior stomach and duodenum.

Omental division with vessel sealer, dividing greater and lesser omental attachments close to the stomach as to preserve blood supply to gastric pouch, extending beyond the pylorus to the level of the gastroduodenal artery.

Duodenal transection performed ~1.5 cm distal to the pylorus using a blue load robotic stapler after confirmation of adequate perfusion with ICG.

Specimen extraction and completion, with complete mobilization and removal of the gastric remnant through an extended port site; bowel continuity confirmed and a drain placed over the duodenal stump.

CONCLUSION

This case highlights pyloric stenosis as a rare but significant cause of gastric remnant outlet obstruction after RYGB. Its presentation decades after the initial procedure demonstrates that pyloric pathology remains a consideration long after foregut reconstruction. Because of limited endoscopic access to the excluded remnant, persistent symptoms warrant careful interpretation of imaging and early surgical consultation. Recognition of this entity broadens the differential diagnosis of post-bypass complications and supports remnant gastrectomy as a reasonable option when prolonged symptoms and obstruction are identified.

REFERENCES:

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