A UNIQUE AND CHALLENGING PRESENTATION OF ABDOMINAL PAIN IN PATIENT WITH GASTRIC BYPASS ANATOMY

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INTRODUCTON

We are presenting an interesting and challenging case of chronic abdominal pain in a patient of gastric bypass surgery. This patient required Endoscopic ultrasound (EUS) directed transgastric Endoscopy (EDGE) for diagnosis and management of pyloric stenosis in a patient with Roux-en-Y gastric bypass anatomy.

CASE DESCRIPTION

History of Presenting Illness

- 61 years old female presented to emergency department with acute worsening of epigastric abdominal pain.
- Patient has history of Roux-en-Y gastric bypass surgery in 2002.
- Pain was present for last 2 years and underwent prior work ups including endoscopies and imaging without any significant etiology identified.

Physical Exam

- Epigastric and right upper quadrant tenderness

Work up & Management

- EGD: short gastric pouch and normal-appearing gastrojejunal anastomosis and jejunal limbs
- Upper GI series: An upper gastrointestinal series and small-bowel follow-through showed normal anatomy.
- CT scan - abdomen significantly distended bypassed stomach (BS) with fluid. Upon further discussion with Radiology, there was abnormal thickening and elongation of the gastric pylorus noted.
- EUS directed transgastric endoscopy (EDGE) was performed revealing significantly dilated bypassed stomach.
- An AXIOS stent was placed between gastric pouch and BS in order to decompress as well as gaining access to pyloric channel.
- Tract was dilated and entered with regular gastroscope. Excessive amount of fluid was aspirated from stomach.
- A severe friable stenosis found at pylorus. This was only traversed with XP190N gastroscope with outer diameter of 5.4 mm.

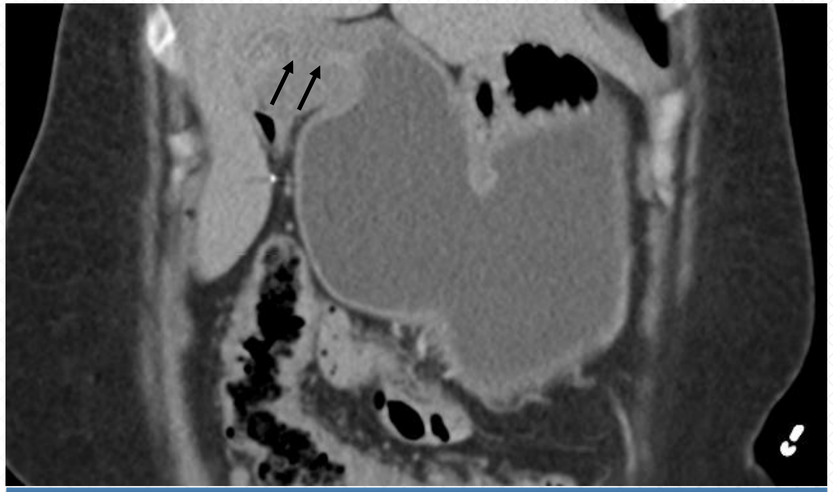

Figure 1 – CT scan of the abdomen showing dilated bypassed stomach with thickened and narrow pyloric channel (Black arrows)

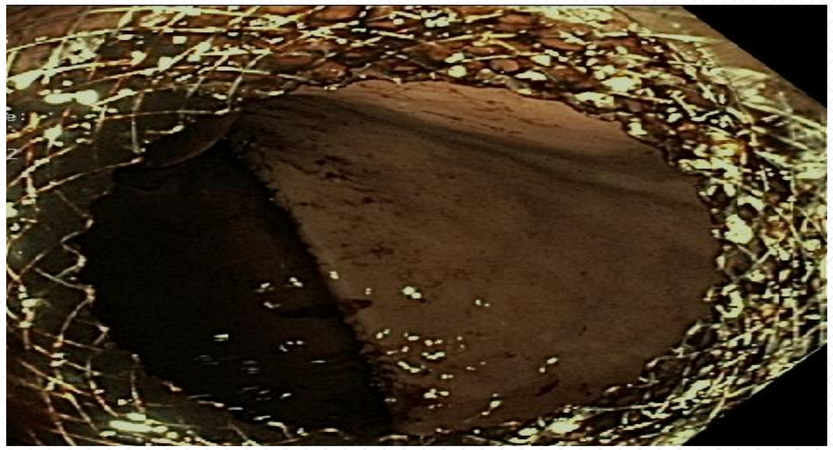

Figure 2 – Endoscopic view of the dilated fluid filled bypassed stomach after placement of Axios stent

CASE DESCRIPTION

- Pathology showed benign inflammation.
- Repeat EGD was performed through the established tract. Pyloric stricture was then dilated up to 12 mm.
- Patient was subsequently discharged in stable condition and followed up in clinic. She reported significant improvement in symptoms.
- Patient remained symptom free on 4 weeks follow up appointment.

Diagnosis: Acquired pyloric stenosis in bypassed stomach.

DISCUSSION

- Despite its overall benefit, there are several early and late complications associated with Roux-en-Y gastric bypass.
- Any pathology in bypassed stomach can lead to abdominal pain including peptic ulcer disease, Helicobacter pylori infection, pyloric stenosis, malignancy etc.
- Diagnosis and management of these conditions in bypassed stomach can be challenging as access to it is not possible with conventional endoscopy.
- Options to gain access to bypassed stomach include laparoscopic assisted endoscopy versus surgical exploration.
- EUS directed transgastric Endoscopy (EDGE) procedure has been routinely performed in order to gain access to biliary tract.
- In our patient EDGE was performed to gain access to bypassed stomach
- This not only provided therapeutic benefits of decompressing significantly distended excluded stomach but also provided access for examining pyloric channel stenosis/thickening concerning for inflammation or neoplasm.
- After confirming benign nature, repeated endoscopy was performed for dilation.
- To our knowledge, this is among first few cases of minimally invasive management of gastric outlet obstruction in patient with gastric bypass anatomy.

CONCLUSION

- Purpose of this case report was to educate respected colleagues about possible etiologies of abdominal pain in bypassed stomach.
- Consider EGDE procedure if concerns of significant abnormality on imaging.