Disguised as Post-Operative Ileus: A Case of a Giant Gastric Ulcer Causing Outlet Obstruction and Gastric Pneumatosis

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Introduction

Giant gastric ulcers (GGU), defined as ulcers **larger than 2-3cm**, are relatively rare in the setting of widespread PPI use.

Though usually located in the lesser curvature, GGU may occur **in any part of the stomach**. Typical symptoms are similar to that of PUD, however GGU are highly **prone to perforation** and **more likely to be malignant** in the elderly.

Overall, gastric outlet obstruction is the least common complication of PUD.

Case Report

A 74-year-old obese male with history of prior laparoscopic gastric banding surgery was admitted for elective surgery for Charcot arthropathy. Post-operatively, he developed nausea, vomiting, abdominal bloating, and tympany on percussion. KUB showed distention of the small bowel concerning for ileus. POD #3 he developed acute anemia without overt bleeding. Repeat imaging showed marked gaseous distention of the stomach and gastric wall pneumatosis (Fig 1a). NG tube was placed for decompression with subsequent resolution of his distention. Due to concern for gastric band erosion, GI was consulted.

EGD revealed a 4cm clean-based ulcer with overlaying eschar along the greater curvature with surrounding erythema and edema (Fig 1b, 1c); the extent and severity of edema appeared to cause relative obstruction at the pylorus. Biopsies showed acute erosive gastropathy with focal clustering of eosinophils without evidence of dysplasia. He was treated with PPI and sucralfate and remained clinically stable without further GI symptoms. His lap band remained in place and did not require deflation. Repeat EGD performed 2 months later showed evidence of scarring and mild erythema in the affected regions, but otherwise complete resolution of the GGU.

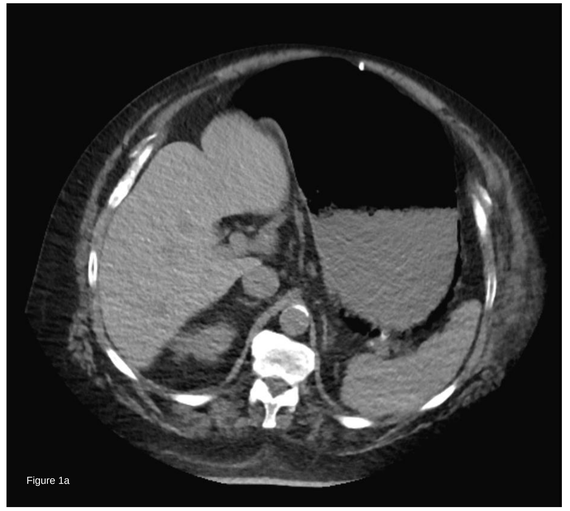

Figure 1a

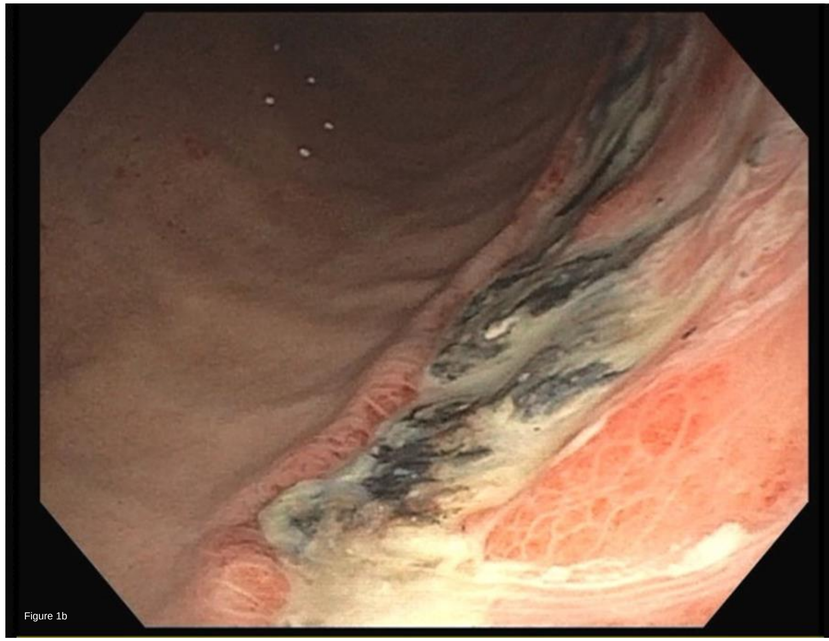

Figure 1b

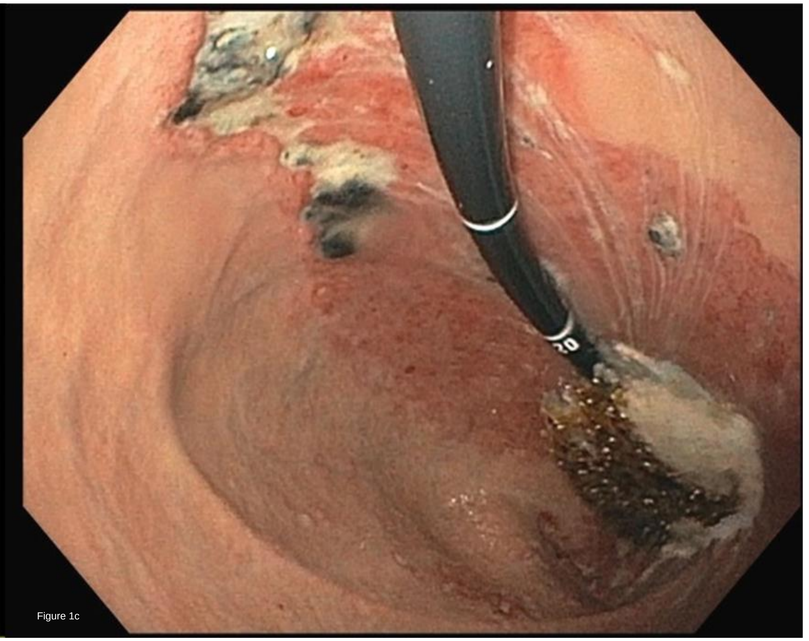

Figure 1c

Discussion

Gastric pneumatosis due to gastric emphysema is caused by disruption of mucosa leading **to air migrating into the gastric wall**.

Etiologies vary, including injury from instrumentation, severe vomiting, pulmonary pathology, penetrating gastric ulcers, or gastric outlet obstruction. Few cases reports have described gastric emphysema resulting from gastric band erosion, however there are no reports describing this occurring in the absence of full erosion.

Overall**, gastric emphysema is relatively rare, as is development of GGU**. To our knowledge, **this is the first reported case of unperforated giant gastric ulcer resulting in partial outlet obstruction with gastric pneumatosis.**

References

Please contact nnarang@email.arizona.edu for references