Bilal Hameed, Uma Mahadevan, and Kay Washington, Section Editors

An Unusual Cause of Gastric Outlet Obstruction

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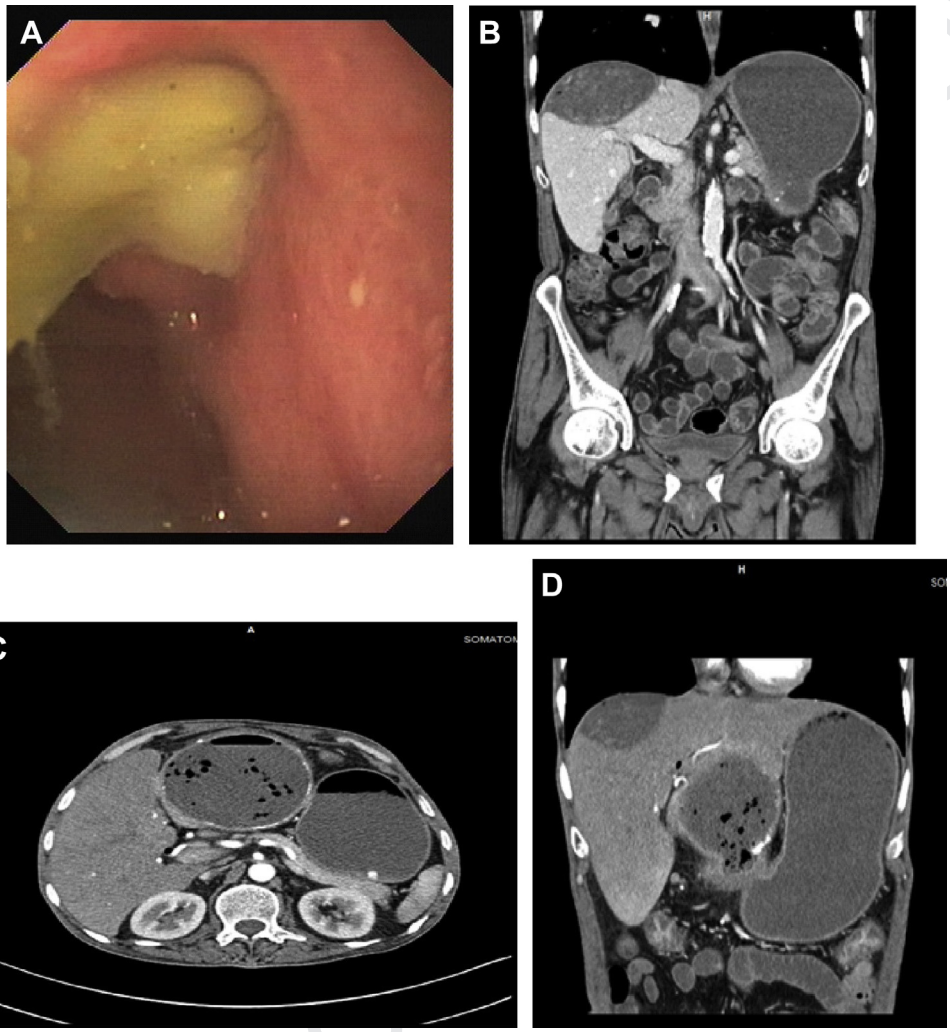

Question: A 50-year-old man presented with complaint of recurrent nonbilious vomiting for 4 months and a weight loss of 66 pounds in the same time frame. Physical examination revealed a tympanitic mass in the epigastrium. Laboratory testing revealed no remarkable abnormalities except for hypoalbuminemia and hypokalemia. In view of recurrent vomiting, a Ryle's tube was inserted and the gastric contents were aspirated. Esophagogastroduodenoscopy demonstrated a fistulous tract on the lesser curvature of the distal stomach in the region of antrum with undulating membranes gushing out from the communication (Figure *A*, Video). Computed tomography scan revealed a 11.80 × 5.6 × 8.5-cm, well-defined, hypodense lesion of fluid attenuation epicentered in the right subphrenic location indenting superior surface of the liver with hyperdense nonenhancing linear strands with curvilinear areas of calcification within it (Figure *B*). Another cystic lesion measuring 10.3 × 8.8 × 10.5 cm was seen epicentered in the left subhepatic region closely abutting the lesser curvature of the stomach in the region of antrum with loss of fat planes (Figure *C*). This lesion showed peripheral wall calcification and a significant amount of air with evidence of breach in wall of the lesion in the posterior inferior aspect. There was evidence of circumferential wall thickening in the gastric antrum measuring up to 1 cm (Figure *D*). Air was seen in suprapancreatic common bile duct and intra hepatic biliary radicals. Serology for *Echinococcus* was negative.

After correction of hypoalbuminemia and dyselectrolytemia, he was taken up for surgery.

What is the diagnosis?

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Conflicts of interest

The authors disclose no conflicts.

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