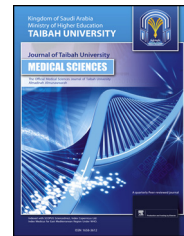




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Case Report

Gastric outlet obstruction secondary to a pedunculated hyperplastic polyp with early malignant changes

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المخلص

الأورام الحميدة مفرطة التنسج هي الأقات الأصبعية الشكل، الأكثر شيوعاً في المعدة ولها أعراض مختلفة. قد تكون عديمة الأعراض، ولكن في بعض الأحيان يمكن أن تسبب فقر الدم وانسداد مخرج المعدة. والمضاعفة التي تُخشى على المدى الطويل من هذه الأورام الحميدة هي التحول الخبيث. نقدم هنا سيدة مسنة اشتكت من تكرار حدوث ألم في أعلى البطن وفي. وأظهر منظار المريء والمعدة والإثني عشر وجود ورم أصبغ كبير على المنحنى الأصغر للمعدة على بُعد 4 سم من ملتقى المريء والمعدة، وكان الورم ممتداً إلى الجزء الأول من الإثني عشر وبدأ تسبب في انسداد مخرج المعدة. وجاء في تقرير الأشعة المقطعية وجود كتلة من النسيج الرخو نابغة من ثلثة المعدة وممتدة من خلال بوابة المعدة إلى الجزئين الأول والثاني من الإثني عشر. تم استئصال الورم بالمنظار، وأظهر الفحص النسيجي المرضي وجود سرطان معدة مبكر. أجري للمريضة متابعة منتظمة بالمنظار مع أخذ خزعة لمدة عامين، وأظهرت المتابعة الأخيرة وجود خلل نسيجي بسيط إلى متوسط في موقع الاستئصال السابق. وخضعت المريضة لاستئصال إسفيني بالمنظار تم التخطيط المسبق له وأكد الفحص النسيجي وجود ورم حميد مفرط التنسج مع خلل تنسجي منخفض الدرجة.

الكلمات المفتاحية: انسداد مخرج المعدة؛ ورم مفرط التنسج؛ ورم خبيث؛ خلل تنسجي منخفض الدرجة؛ ورم أصبغ

Abstract

Hyperplastic polyps are the most common polypoidal lesions of the stomach showing a varied presentation. They may be asymptomatic; however, occasionally they can cause anaemia and gastric outlet obstruction.

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Malignant transformation is a serious complication associated with such polyps. We present the case of an elderly woman who complained of epigastric pain and intermittent vomiting. Oesophagogastroduodenoscopy (OGDS) showed a large pedunculated polyp along the lesser curvature of the stomach, 4 cm from the gastro-oesophageal junction, extending into the first part of the duodenum that caused gastric outlet obstruction. Computed tomography reported a soft-tissue mass arising from the incisura and extending through the pylorus into the duodenum (D1 and proximal D2). An endoscopic polypectomy was performed, and histopathological examination reported evidence of early gastric carcinoma. She underwent regular endoscopic follow-up with biopsies performed over 2 years, and the last follow-up showed mild-to-moderate dysplasia at the previous excision site. She underwent a planned laparoscopic wedge resection, and histopathological examination confirmed the presence of a hyperplastic polyp showing low-grade dysplasia.

Keywords: Gastric outlet obstruction; Hyperplastic polyp; Malignancy

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Introduction

With the advent of endoscopy and its widespread use as a diagnostic tool for upper gastrointestinal pathology, gastric

polyps are detected in approximately 6% of all OGDS performed and 1% of autopsies.¹ The polyps could be hyperplastic, adenomatous, or carcinomatous in nature.² Hyperplastic polyps are the most common polypoid lesions, representing 75–90%.³ Their presentation could vary from small asymptomatic polyps to large lesions causing bleeding, abdominal pain, gastric outlet obstruction, and/or iron deficiency anaemia.⁴ A few polyps, for example, the hyperplastic ones are associated with *Helicobacter pylori* infection and their disappearance following *H. pylori* eradication has been proven.^{5,6} Although low, the risk of malignant transformation remains a primary concern with both, hyperplastic and adenomatous polyps.^{2,6} Identification of specific pathological characteristics is important to distinguish between hyperplastic and adenomatous lesions. This case is unique in that this patient presented with a polyp measuring >3 cm that caused gastric outlet obstruction, and histopathological examination showed evidence of malignancy arising against a background of a hyperplastic polyp.

Case presentation

A 61-year old woman with history of underlying type II diabetes mellitus presented to our surgical outpatient department with complaints of epigastric pain, early satiety, loss of weight, and intermittent vomiting over 2 months. She had no past history of dyspepsia or use of proton pump inhibitors. On examination, her body mass index was 17, and laboratory investigations showed mild hyponatraemia and hypokalaemia.

Abdominal contrast-enhanced computed tomography showed a distortion of the normal configuration of the body of the stomach and a soft-tissue mass arising from the incisura, extending through the pyloric antrum and pyloric canal into the duodenum (D1 and proximal D2), measuring approximately 3.8 × 8.0 × 4.6 cm with an impression of the pyloric antrum to the D2 mass (Figure 1). An initial OGDS performed revealed a large pedunculated polypoid mass measuring 5 cm in diameter that was observed to have prolapsed into the duodenum, with the base arising from

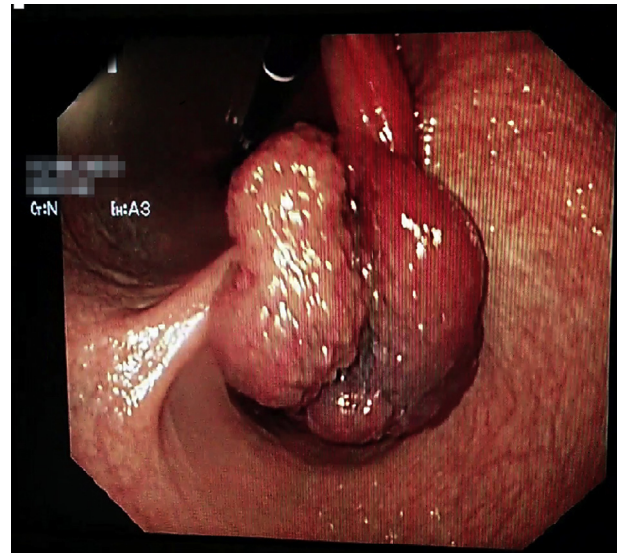


Figure 2: Endoscopic view showing a pedunculated polyp traversing the pylorus.

the proximal greater curvature of the stomach, 4 cm below the gastro-oesophageal junction, arising from the posterior wall and lesser curvature (Figure 2). Endoscopic resection under general anaesthesia was planned after cardiac assessment. Operative findings revealed a large polyp measuring approximately 5 × 5 cm in the proximal stomach, located 4 cm from the gastro-oesophageal junction, arising from the posterior wall of the lesser curvature. The lesion was delivered from its resting position within the pyloric canal prior to performing a piecemeal resection. Histopathological examination at our hospital suggested an early gastric carcinoma (pT1NxMx) with no evidence of *H. pylori* infection. We observed an elongated tortuous and hyperplastic foveolar epithelium along with cystic changes (Figures 3 and 4) and an area of malignant glands present in the lamina propria (Figure 5). An OGDS repeated at 8 weeks showed a scar at the previous excision site with a minimal mucosal lesion, which was biopsied in addition to

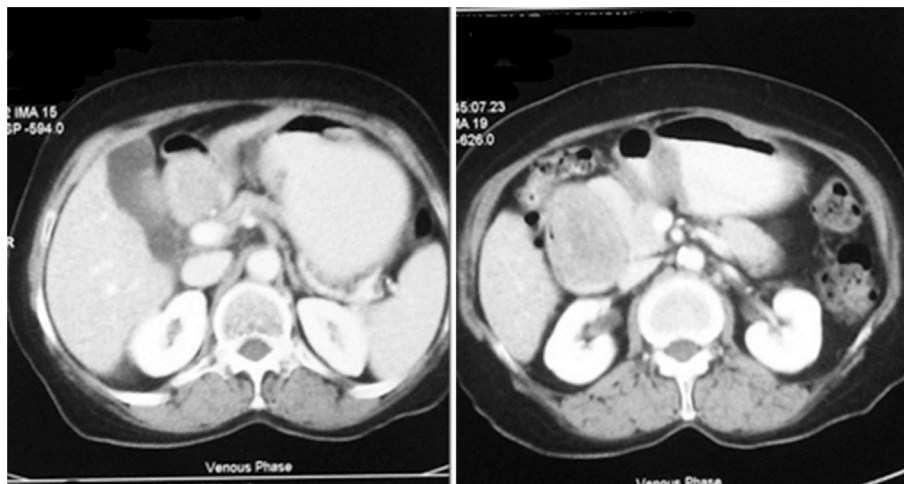


Figure 1: Computed tomography (CT) scan showing a soft-tissue mass extending into the pylorus.

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