

Deep Gastric Ulcer with Formation of Fistula along the Stomach Wall

¹Abu Taiub Mohammed Mohiuddin Chowdhury*, ²Du Jing Feng, ³Liu Min and ⁴Cuiying

Department Of Digestive Disease-II, The First Affiliated Hospital of Jiamusi University, Heilongjiang. P.R. China

***Corresponding Author:** Abu Taiub Mohammed Mohiuddin Chowdhury, Department of Digestive Disease-II, The First Affiliated Hospital of Jiamusi University, Heilongjiang. P.R. China, E-mail: dr_mohiuddinchy@yahoo.com

A deep Gastric ulcer with formation of fistula buried in the posterior stomach wall, at the lower half of the body of the stomach along the lesser curvature in a 65 years old male patient was evaluated while undergoing “Esophagogastroduodenoscopy” for clinical features resembled to simple mild gastritis not responding to Proton Pump Inhibitor therapy. The channel was about 3 cm long, buried in to the posterior wall of the stomach close to the lesser curvature comparatively constricted opening of 0.8 cm, approximately 4.5 cm above the pyloric sphincter. The patient was overweight, hypertensive, non-diabetic, non-smoker with irregular alcohol consumption and no regular history of NSAID. His C13 Urea breath test was found negative and histopathological examination of biopsy specimens confirmed diagnosis of Carcinoma

We report a case of gastrojejunal fistula caused by benign gastric ulcer, a very rare condition. The patient was an 81-year-old-woman who had had multiple recurrences of gastric ulcer. She also had diabetes mellitus. She was admitted to our hospital because of a left femoral head fracture, necessitating a mechanical bone head exchange operation. She had severe abdominal pain and anemia on the 48th postoperative day. Gastroendoscopic examination revealed a giant ulcer with a long-axis diameter of more than 5cm on the lesser curvature of the gastric body. She was treated with intravenous famotidine and all oral intake was restricted; her symptoms were alleviated. Two weeks later, a fistula had formed between the stomach and the jejunum just anal to the duodeno-jejunal flexure. She was placed on an ulcer diet, and was discharged with no symptoms on the 151st postoperative day. She has remained asymptomatic for 1 1/2, years to date. Lack of H2-antagonist administration, operative stress, and administration of ipriflavone appeared to have induced gastric ulcer recurrence, and formation of the fistula between the stomach and the jejunum seemed to have been facilitated by the patient being very lean and having minimal mesenteric adipose tissue.

Spontaneous gastrojejunal fistula formation is an extremely rare complication of gastric ulcer disease. We report a 77-year old woman who presented with diffuse abdominal pain, weight loss, malaise, nausea, and occasional dark stools. Laboratory tests showed extreme hyposideremic anemia with inflammatory syndrome. In addition, biochemical parameters of malnourishment were presented

Upper endoscopy revealed the patent esophagus along the full length without any pathological changes. Large and deep ulceration with perforation in the small intestine was detected in the posterior gastric wall. The small intestine loop was reached by endoscope through spontaneously developed gastrojejunal fistula.

Polytopic biopsies of described ulcerative change were carried out. Histopathologically reepithelialized ulcerous zone was seen in the gastric mucosa. Also, gastrojejunal fistula was visualized after wide opening of hepatogastric and gastrocolic ligament. Jejunal loop 25 cm from ligament of Treitz was attached to mesocolon and posterior gastric wall because of ulcer penetration. Postoperative course was uneventful. Per oral intake started on the 4th postoperative day, and the patient was discharged on the 8th postoperative day. In summary, this case indicates that persistent symptoms of peptic ulcer disease associated with nutritional disturbances may be caused by gastrojejunal fistula.

The inflammatory response to deeply penetrating peptic ulcer can lead to formation of a fistula between the stomach and duodenum or any structure nearby. Fistulae to the pancreatic duct, biliary tract, and colon have been described more commonly. Fistula arising between the stomach and duodenum called “double pylorus” is also a well-recognized complication of peptic ulcer disease. Rarely, duodenal ulcer can penetrate to adjoin vascular structures and induce aorto-enteric or cavo-enteric fistula. Such fistulae are usually characterized by less acute symptoms and in some instances represent a very challenging problem. In each case in which fistula is identified, cancer must be considered in differential diagnosis. In general, the small intestine is not found in proximity to the stomach or duodenum, protected as it is by the transverse colon and mesocolon. However, fistula to the small intestine has been reported to occur with typical ulcer symptoms. We present a case of gastric ulcer disease complicated by gastrojejunal fistula.

Please Submit your Manuscript to Cresco Online Publishing

<http://crescopublications.org/submitmanuscript.php>