

Epigastric lump: An Unusual Presentation Of Erosive Hemorrhagic Gastritis

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Abstract

Bleeding from stress induced erosive gastritis is a potentially life-threatening condition in critically ill patients. The key to its prevention are provision of sufficient visceral perfusion and acid-suppressive measures. Various surgical and non-surgical methods have been described to manage such rare entities. The incidence of this condition has decreased due to regular prescription of effectively acid-suppressing drugs in critical patients. The authors present one of these rare cases. The awareness of such an unusual presentation of erosive gastritis may help in timely intervention and avoid potential mortality.

INTRODUCTION

Stress induced erosive gastritis occurring in critically ill and injured patients can be managed conservatively with drugs and rarely requires surgical intervention. We report one such case who presented with an epigastric lump due to clot retention in the stomach requiring surgical treatment.

CASE REPORT

A 20-year-old female developed inter-gut loop abscess due to puerperal sepsis following preterm labour six months ago. She presented with features of sub-acute intestinal obstruction. Ultrasonography revealed free fluid in the pelvis and in the peritoneal cavity. A collection of the size 7x9cm with fine internal echoes was seen in the right sub-hepatic region which was found to be pus on needle aspiration. The patient was explored after failure of response to conservative treatment. About three liters of pus were drained from the peritoneal cavity and the collection in the right sub-hepatic region was found to be eroding into the second part of the duodenum. A small duodenal perforation (0.5x0.5cm) was detected after drainage of this collection. Thorough peritoneal lavage, adhesiolysis and T-tube drainage of the perforation was done. In the post-operative period, the patient was nursed in the high dependency area and required inotropic support for hemodynamic instability for five days. Ryles tube aspiration was continued and T-tube drained around 1500 ml. bile per day. Apart from antibiotics and proton pump inhibitors, the patient was given parenteral alimentation. Enteral feeding could not be started due to persistent ileus. On the 15th post-operative day, the patient

developed sudden epigastric fullness reaching up to the umbilicus along with tachycardia and hypotension. Clinical examination was suggestive of a distended stomach. On gastric lavage with saline, mildly hemorrhagic fluid was aspirated. Upper GI endoscopy revealed a stomach full of blood clots. Platelet count and prothrombin time were found to be normal. Since gastric lavage was ineffective, the patient was subjected to surgical exploration. The stomach was found to be hugely distended and about two liters of blood clots were evacuated through anterior gastrotomy. The underlying gastric mucosa was found to be congested and edematous with areas of sloughing in whole of the stomach. There was no fresh bleeding and the stomach was closed over a tube gastrostomy. There was no recurrent gastric bleeding in the post-operative period. The biopsy from gastric mucosa revealed non-specific inflammatory changes. The patient had burst abdomen that was treated conservatively. However she could be salvaged after a stormy and prolonged hospital stay.

DISCUSSION

Bleeding from stress erosive gastritis is a potentially life threatening condition occurring in critically ill patients. The key to its management is prevention by providing adequate visceral perfusion and acid suppression therapy in all high risk patients₁. In the event of bleeding occurring despite these preventive measures, aggressive medical management helps in controlling the bleeding in over 80% of the cases₂. In the remaining few cases not responding to medical treatment, operative approach in form of conservative

surgery is indicated. However, no operation has been recognized as procedure of choice in such cases. The recommended procedures vary from vagotomy and pyloroplasty with over-sewing of bleeding erosions to gastric devascularisation or gastrectomy^{2,3,4,5}. In the present case, sepsis, hypotension and prolonged parenteral nutrition were possible stress factors for erosive hemorrhagic gastritis. The bleeding episode from the gastric mucosa was probably acute and massive leading to clot retention and gastric dilatation. The clots could not be evacuated due to their large volume requiring surgical removal. Deep suturing of gastric mucosa, as recommended in the literature for such cases, was not needed since there was no active bleeding site. The awareness of such an unusual presentation of erosive gastritis may help in timely intervention and can avoid

potential mortality.

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