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Case Report

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A large Gastric Diverticulum: A Rare Endoscopic Finding

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1. Abstract

1.1. Introduction: A gastric diverticulum is a rare form of diverticular disease due to outpouching of the gastric wall. The rates of detection vary depending upon the method used to detect them. Occasionally, complications, such as ulceration, upper gastro intestinal bleeding, hemorrhage, perforation, and malignant transformation, can develop that may be life-threatening and are indications for surgical management.

1.2. Case Presentation: A 64-year-old female presented with a one-month history of upper abdominal pain and anorexia. There was no history of dysphagia, vomiting, hematemesis or melena. There was no history of Helicobacter pylori eradication therapy or upper abdominal surgery. Gastroscopy showed a wide-mouthed diverticulum of the size of 3×2 cm in diameter at the antral lesser curvature. The patient's symptoms proved after four weeks' therapy with proton pump inhibitors.

CONCLUSION: Gastric diverticula are rare conditions which are largely asymptomatic but may present with varying signs and symptoms and may requires urgical intervention.

2. Introduction

Gastric diverticulum is defined as an outpouching of the gastric wall [1]. They are uncommon, with an incidence between 0.01–0.11% [2]. It usually occurs in the fifth and sixth decades, with equal distribution among men and women, and can be congenital or acquired. They have features similar to those of small bowel diverticula and colonic diverticula [3].GD are the least common gastrointestinal diverticula, and are very rare anatomic abnormalities overall. In fact, the rates of detection vary depending upon the method used to detect them. Estimates of prevalence range from 0.04% (165/380,000) in upper gastrointestinal contrast idiographic studies to 0.01–0.11% in upper gastrointestinal endoscopies to 0.02% (6/29,900) in autopsy studies [4, 5–6]. Occasionally, complications, such as ulceration, upper gastrointestinal bleeding, hemorrhage, perforation, and malignant transformation, can develop that may be life-threatening and are indications for surgical management [7,8]. Here we present a case of a large gastric diverticulum, with discussion of the presentation, investigations and management options of this condition.

3. Case Report

A 64-year-old female presented with a one-month history of upper abdominal pain and anorexia. There was no history of dysphagia, vomiting, hematemesis ormelena. There was no history of Helicobacter pylori eradication therapy or upper abdominal surgery.

Gastroscopy showed a wide-mouthed diverticulum of the size of 3×2 cm in diameter at the antral lesser curvature (Figure 1). Biopsies showed mild inflammation and were negative for Helicobacter pylori. The pain was reproduced by probing the divert iculum with biopsy forceps as well as by in sulfating it with air. The patient's symptoms improved after four weeks' therapy with proton pump inhibitors.

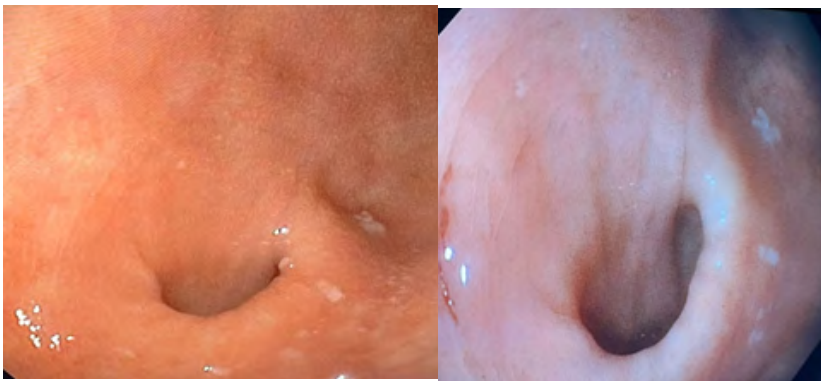

Figure 1: A large antraldiverticulum

4. Discussion

Patients often present with vague and variable symptoms. In a literature review conducted by Rashid et al. [9]. Gastric diverticulum can be congenital, which are true diverticula or acquired which are false diverticula. It can remain asymptomatic or can present with symptoms such as upper abdominal pain, dyspepsia, weight loss, anaemia, reflux or even bleeding and perforation. The diagnosis may be difficult, as complaints can be caused by more common gastrointestinal pathologies and only be aggravated by diverticula. Methods of detection can fail, therefore, a combination (e.g. endoscopy, ultrasound and upper gastro intestinal barium studies) should be used. Moreover, there have been a few reports of neoplasia arising in gastric diverticulum (Oya, Akahoshi, &Toyomasu, 2012). Seventy-five percent of true gastric diverticula are located in the posterior wall of the fundus of the stomach, 2 cm below the gastro-oesophageal junction and 3 cm from the lesser curve, with a size range between 3 and 11 cm [10]. The management of patients with gastric diverticulum depend largely on their symptoms. There is no specific treatment required for an asymptomatic diverticulum [9] is well documented that asymptomatic individuals do not require any treatment and can be left alone [11, 12, 13, 14]. Patients with GD who are symptomatic should initially be treated with PPI therapy, histamine H2 receptor antagonist therapy, or antacid therapy. PPI therapy for several weeks has been reported to alleviate symptoms in confirmed cases of GD [13]. Surgical treatment is recommended for large, symptomatic or complicated (perforation, bleeding or malignancy) diverticula. Palmer et al. [1] Both open and laparoscopic resection yield good results. Perioperative gastroscopy can help locate the diverticulum in difficult situations. Laparoscopic access to the posterior aspect of the gastric fundus is possible after the gastrocolic ligament has been divided [6].

5. Conclusion

Gastric diverticula are rare conditions which are largely asymptomatic but may present with varying signs and symptoms. Laparoscopic resection, sometimes assisted by intra operative endoscopy, is a safe and feasible surgical treatment that should be offered when GD are large, patients have not responded adequately to medical treatment, and complications have occurred.

References

1. Palmer ED. Gastricdiverticulosis. Am. Fam. Phys. 1973; 7(3): 114-117.
2. Mohan P, Ananthavadivelu M, Venkataraman J. Gastric diverticulum. Can. Med. Assoc. J. 2010 ; 182(5) : E226.
3. Chen JH, Su WC, Chang CY, Lin H. Education and imaging. Gastrointestinal: bleeding gastric diverticulum. J Gastroenterol Hepatol. 2008; 23(2): 336.
4. Gockel I, Thomschke D, Lorenz D. Gastrointestinal: gastric diverticula. J Gastroenterol Hepatol. 2004;19(2): 227.
5. Rodeberg DA, Zaheer S, Moir CR, Ishitani MB. Gastricdiverticulum: aseries of four pediatric patients. J Pediatr Gastroenterol Nutr. 2002; 34(5): 564-7.
6. Donkervoort SC, Baak LC, Blaauwgeers JL, Gerhards MF. Laparoscopicresection of a symptomaticgastricdiverticulum: a minimally invasive solution. JSLS. 2006; 10(4): 525-7.
7. DuBois B, Powell B, Voeller G. Gastric diverticulum: "a wayside house of illfame" with a laparoscopic solution. JSLS. 2012; 16(3): 473-7.
8. Ho MF, Teoh AY, Liu SY, Chiu PW, Wong SK, Ng EK, et al. Perforated gastric diverticulum with bleeding. Endoscopy. 2013; 45 Suppl 2 UCTN: E422-3.
9. Rashid F, Aber A, Iftikhar SY. A review on gastricdiverticulum, World J. Emerg. Surg. 2012; 7:1.
10. Hernández GH, Soto ICF, Garcia CAJ. Gastricdiverticulum: a rare endoscopic finding. J. Hepatol. Gastroint. Dis. 2016.
11. Palmer ED. Gastric diverticula. Int Abstr Surg. 1951; 92(5): 417-28.
12. Reich NE. Gastric diverticula. Am J Dig Dis. 1941; 8(3): 70-6.
13. Ohan P, Ananthavadivelu M, Venkataraman J. Gastric diverticulum. CMAJ. 2010; 182(5): E226.
14. Palmer ED. Gastric diverticulosis. Am Fam Physician. 1973; 7(3): 114-7.