

**Benign intermittent gastric outlet obstruction in an elderly: Endoscopic management and brief review**

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**Abstract:**

*We describe the clinical scenario in an 80 year old female who presented with history of epigastric discomfort and postprandial fullness of three weeks duration without any alarming symptoms. On upper GI endoscopy she was found to have gastric polyp with a long stalk which was partially obstructing her pyloric ring giving rise to features of intermittent gastric outlet obstruction Polypectomy was done with complete relief of symptoms .She is following our clinic for last 6 months now. Although possibility of malignant etiology in gastric out let obstruction ranks high in the elderly some patients are lucky to have a benign cause as the index case. Report of the case and brief review is presented.*

**Key words:***Inflammatory polyp, Gastric outlet obstruction.*

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**Case Report:**

An 80 year old female presented to our clinic with history of post prandial fullness, nausea and intermittent postprandial vomiting of 3 weeks duration without any history of anorexia or weight loss. On examination she was conscious oriented hemodynamically stable with no pallor, lymphadenopathy cyanosis or jaundice. Her systemic examination was normal .On laboratory evaluation she had hemoglobin of 15.3gm/dl. normal liver and kidney function tests. Her gastroscopic examination revealed normal esophagus. gastric fundus and body.Antrum showed 1.5 cm size head polyp with 3cms long stalk freely mobile moving inside the pyloric ring with the two parts of head (Fig.1,2.) Moreover there was a 2cm long deep ulcer noted in antrum distal to polyp(Fig.3). Polypectomy snare was used and the polyp was resected close to the base with no significant bleeding. Two clips were applied (fig4) to the polypectomy base and polyp was removed out of

stomach with endoscopy net. Patient was observed overnight and later discharged home without any complications. The biopsy of the resected polyp revealed hyperplastic /inflammatory polyp (Fig.5) Antral biopsy was suggestive of mild chronic gastritis with no intestinal metaplasia or dysplasia and no H .pylori was identified. She was maintained on oral Esomeprazole 20mg twice daily for 3 months .Repeat endoscopy after 5 months showed complete resolution with no recurrence at the base of polyp and complete healing of antral ulcer (Fig.6).The biopsy was normal She is feeling fine with marked relief in her intermittent obstructive symptoms and is on our follow up for last 6 months now

**Discussion**

Hyperplastic polyps are the most common polypoidal lesions of the Stomach. Gastric polyps remain undetected in 50% of patients who have no symptoms<sup>1</sup> Patient may present with features of symptomatic anemia or vague symptoms attributable to chronic blood loss. Less than 10% of patients can present with hemtemesis. Rarely, they cause gastric outlet obstruction by prolapsing through the pyloric channel,<sup>2,3</sup> when they arise in the prepyloric area as in the index case. Intermittent, partial obstruction is due to the inward movement of the polyp, a ball valve effect, caused by peristalsis. In the differential diagnosis, it is important to distinguish namely eosinophilic gastroenteritis, gastrointestinal stromal tumor, inflammatory pseudo tumor, hemangioendothelioma etc. The exact pathogenesis of hyperplastic polyps is still unclear. The current theory is that an exaggerated regenerative response to mucosal damage occurs<sup>2</sup>. There are conflicting data regarding the association of H.pylori and polyps. In a placebo controlled trial of 35 patients Some workers<sup>4,5</sup> observed that H.pylori eradication significantly reduced these polyps and authors advocated H.pylori eradication before endoscopic removal particularly if the polyps were

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Fig1: EGD showing polyp prolapsing into duodenum

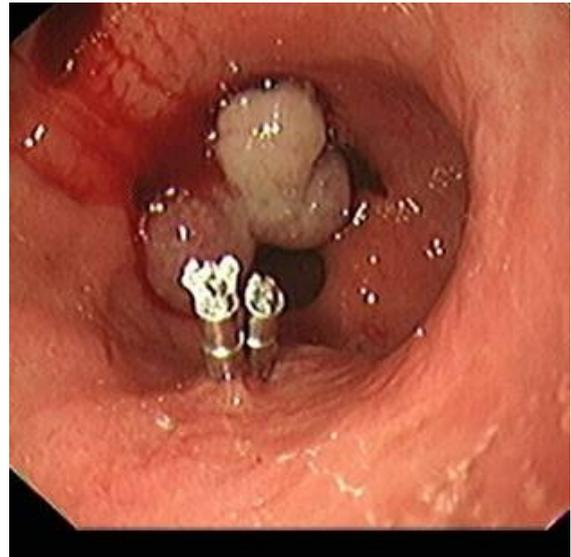


Fig. 4: Polypectomy and application of two clips

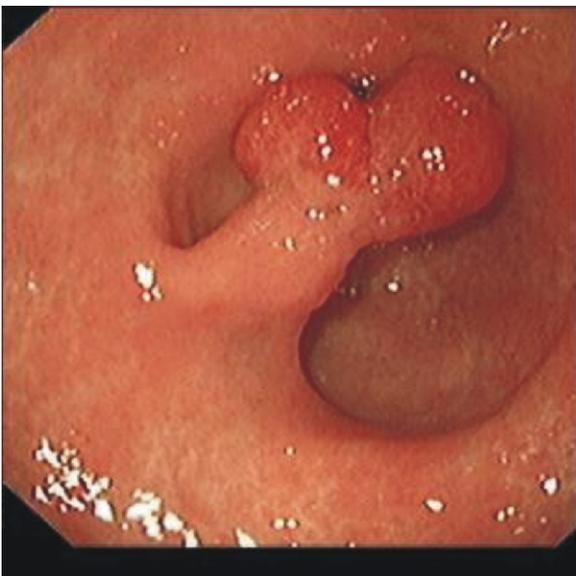


Fig 2: polyp with Bilobed head and long stalk

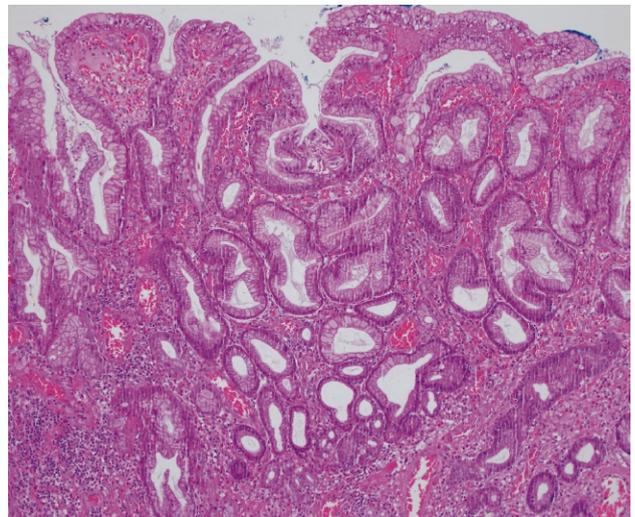


Fig.5: Histology of the polyp



Fig 3: Antral ulcer



Fig. 6: Follow-up EGD showing the base of of polypectomy site

multiple and didn't cause obstructive symptoms. Contrary to this Varis et al<sup>6</sup> observed that the prevalence of H.pylori was significantly lower in patients with hyperplastic polyps than in foveolar hyperplasia. Authors suggested that the polyps with hyperplastic changes are in some of the cases closely related to autoimmune gastritis. Whatever is the causative mechanism resection of a large polyp is agreed by all<sup>8,9,10</sup>. The treatment of choice is endoscopic polypectomy which is a safe procedure, however there are reports of post procedure bleeds controlled by endotherapy, use of endoclips with good results has also been reported in the literature<sup>7</sup>. Successful endoscopic removal of gastric polyps in a series of four patients was reported by Kumar et al<sup>7</sup>. All patients in their series were symptomatic like that of the index case and none of the

patients had malignancy on biopsy. Freeman<sup>8</sup> initially reported malignancy in the prolapsing polyp later two studies<sup>9, 10</sup> revealed that hyperplastic polyps may harbor dysplastic foci and even undergo malignant degeneration. The incidence of malignancy in these lesions is to the tune of 2% as reported by Hizawa et al<sup>9</sup> so endoscopic removal is mandatory to rule out malignancy. Polyps of more than 2cms size must be removed and biopsied and patients put on endoscopic surveillance to rule out malignancy on follow-up.

### Conclusion

Gastric polyps occasionally present with intermittent outlet obstruction. Endoscopic excision of these polyps is safe modality and determines the exact histopathological type of the polyp besides offering a radical cure.

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