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Double Pylorus: Case Report of Atypical Presentation

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Double Pylorus: Case report of atypical presentation

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Introduction

Double pylorus is a rare endoscopic finding that has been reported in 0.001% to 0.4% of upper gastrointestinal endoscopies, consisting of a gastroduodenal fistula extending from the prepyloric gastric antrum to the duodenal bulb through an accessory channel. In the majority of cases, it is a complication when peptic ulcers erode and create a fistula between the duodenal bulb and the distal stomach. It usually presents on the lessor curvature of the gastric antrum and on a superior wall of the duodenal bulb. It is commonly an endoscopic finding, since clinical presentation is similar to other peptic diseases.

Clinical Course

The patient was a 62-year-old female presented to the ED for evaluation of intractable nausea and vomiting. The patient reported sudden onset of symptoms day prior, with multiple episodes of brown-colored liquid emesis. Patient denied any associated abdominal pain, no postprandial association with food. CT showed significant mucosal thickening of the gastric antrum to proximal duodenum, resulting in severe dilation of the stomach with air fluid level. Nasogastric tube was then placed for decompression and serial KUB showed adequate position and non-obstructive bowel gas pattern. An esophagogastroduodenoscopy revealed moderate gastritis and antral duodenal fistula, an accessory channel was noted on the lesser curvature side and once engaged was able to be passed with the endoscope. Pathology returned reactive mucosal changes suggestive of focal erosions, Helicobacter Pylori returned negative.

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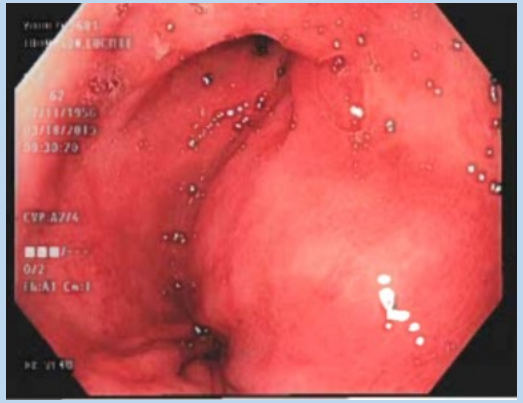

Figure 1: Double pylorus seen in gastric antrum

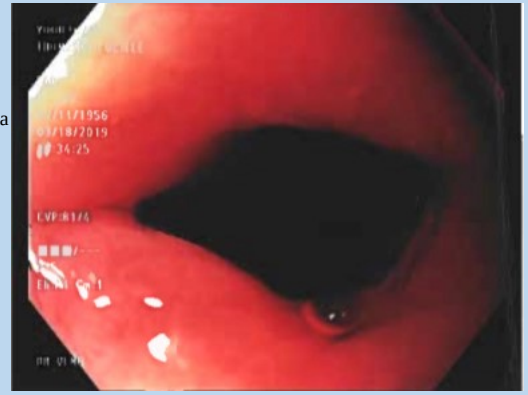

Figure 2: Gastroduodenual fistula after insuflation

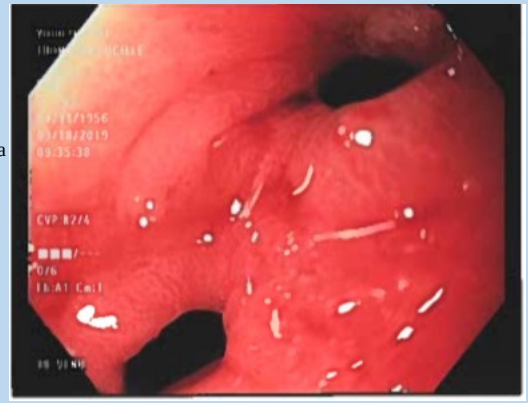

Figure 3: After passing endoscope through fistula

Discussion

The majority of reported cases of double pylorus are acquired and are attributed to complications of ulcers at the antrum-pyloric area or at the duodenal bulb. Acquired double pylorus typically present symptomatic with chronic upper abdominal pain, vomiting, dyspepsia, or upper gastrointestinal bleeding. Patients often have a long history of treatment with NSAIDs or corticosteroids, which should prompt an investigation for Helicobacter pylori and eventual treatment if found positive. Medications for the reduction of peptic acid should be taken and ulcerogenic medications should be avoided. The majority of patients respond well to medical treatment, according to a retrospective follow-up study in patients treated with H2 receptor antagonist or proton pump inhibitor after the diagnosis of acquired double pylorus, the fistula remained open in the majority of patients (64%), fused with normal pylorus in 27% of patients and closed only in 9% of cases.

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