

Giant Gastric Polyp, A Rare Cause Of Gastric Outlet Obstruction

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Abstract

Gastric polyps are often an incidental finding on upper gastrointestinal endoscopy. Hyperplastic polyps are the most commonly encountered gastric polyps (75%). Most of gastric polyps are asymptomatic but they may present with occult bleed, obstruction or abdominal pain. We report a case of an 80-year-old woman who presented with a benign gastric polyp causing an intermittent gastric outlet obstruction, who was successfully treated with resection.

Keywords: Gastric polyp; Gastric outlet

Introduction

Gastric polyps most frequently originate in the mucosa, but include a broad spectrum of pathological conditions, that may be even submucosal or extrinsic [1]. Histologically, they can be classified as hyperplastic polyps, adenomatous polyps, fundic gland polyps and inflammatory polyps [2]. Gastric hyperplastic polyps are associated with *H pylori gastritis*, while fundic gland polyps are with proton pump inhibitor use [3].

Gastric polyps are a rare entity, with an incidence of 3-5% in Japan [1]. Most patients are asymptomatic. Symptomatic presentation can vary from occult bleeding to complete gastric outlet obstruction. Most polyps have no risk of cancer, but there are certain subsets of polyps with malignant potential.

We describe a case of intermittent gastric outlet obstruction by a giant hyperplastic polyp and its subsequent management.

Case Report

An 80-year-old independent woman, with a background of intolerance to aspirin, asthma, anxiety, diverticular disease and chronic venous insufficiency, presented with a combination of severe abdominal pain and intermittent vomiting of partially digested food after meals.

Four months before admission she started with food intolerance and gradual weight loss (5 Kg in three months).

At admission, laboratory tests revealed hyperamylasemia, and she was diagnosed with a mild acute pancreatitis.

CT-scan showed thickness of the antral gastric wall with atypical gastric morphology.

Upper endoscopy revealed a gastric volvulus, solved by the endoscopist, and an ulcerated mass. Edema and thickness of the wall down to the second duodenal portion. Biopsy of the mass didn't show malignancy (Figures 1-3).

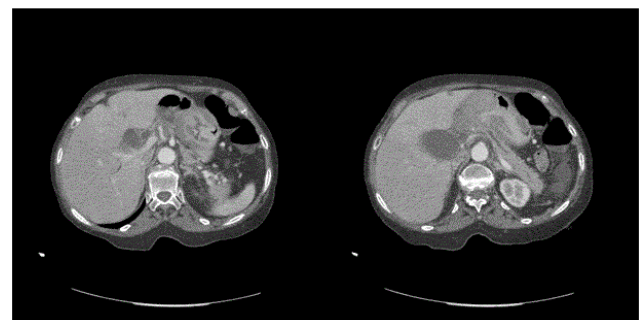


Figure 1: Tomography showing thickening of the gastric antrum and duodenum.

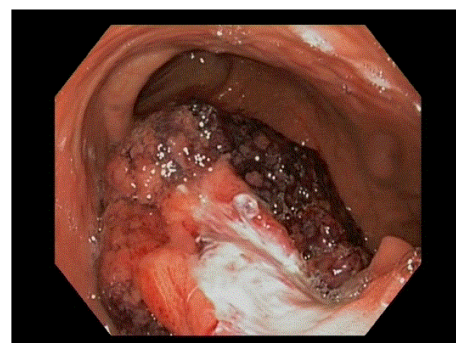


Figure 2: A gastroscopy revealed a huge semi-pedunculated polyp (11 cm) with smooth surface, which originated at the posterior wall of the gastric body. The histology of specimens obtained with biopsy forceps showed inflammatory exudate, granulation tissue with necrosis.

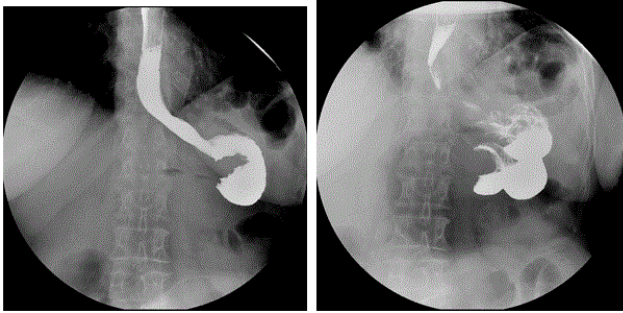


Figure 3: The upper GI series shows image of repletion defect, creating the gastric fundus without infiltration.

Due to the suspicion of malignant tumour causing a gastric outlet obstruction, poor oral intake and without histological confirmation, surgical treatment was recommended. A transverse gastrotomy exposed a 10 cm pedunculated polyp, arising from the posterior wall of gastric fundus. This polyp was seen prolapsing into the duodenum, causing intermittent gastric outlet obstruction. The polyp was excised with Endostapler and sent for pathology (Figures 4-6). There were no postoperative complications.

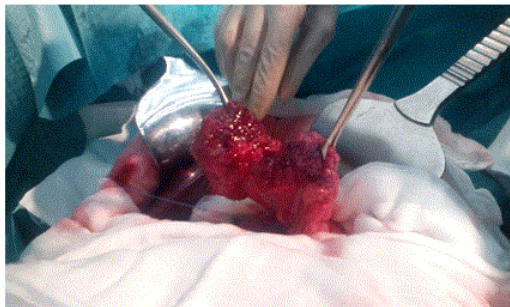


Figure 4: Gastric tumour, about 10 cm wide, which was originated at the posterior wall of the fundus.

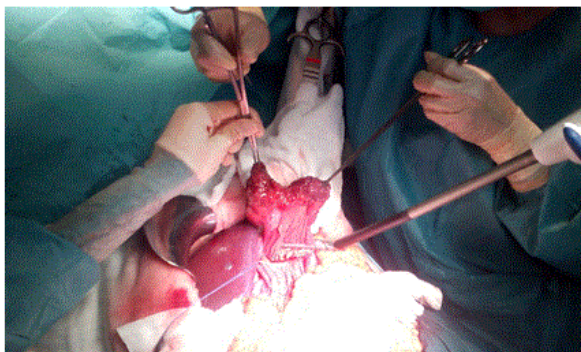


Figure 5: Transverse section of the base with Endostapler.

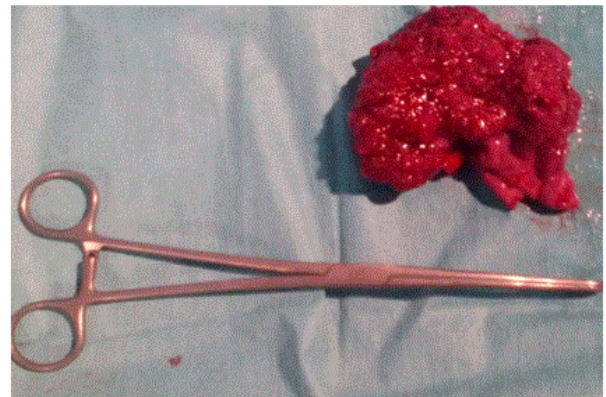


Figure 6: Postoperative specimen. The tumour was completely resected without any complications. It was an 8.5 × 7x4.5 cm sized polyp. The histology showed a hyperplastic polyp, limited to the mucosa, without metaplasia, dysplasia, or malignancy, and no evidence of *H. pylori*.

Discussion

Hyperplastic or regenerative polyps are the most common kind (75-90%) [2]. Most are an incidental finding on upper endoscopy. Symptomatic presentations can range from an ulcerated polyp leading to anaemia and occult bleed to complete gastric outlet obstruction. Frequency of malignant transformation is 1.5-3% of hiperplastic polyps [2]. Polyps that are greater than 1 cm have a higher risk of neoplasia [2].

The treatment of gastric polyps is excision. In some studies, there have been reports od co-ex of *H. pylori* and hyperplastic polyps. Eradication of *H. pylori* resulted in regression of the existing polyps and prevented new polyps to develop. Surgical treatment is recommended in polyps greater than 2 cm, sessile polyps, and failure of endoscopic treatment.

Incidence of gastric outlet obstruction due to polyps is unknown, with only few cases reported in literature [3-8]. Differential diagnose should be made with peptic ulcer, gastric or pancreatic carcinoma, duodenal polyp, pancreatitis and Crohn disease, among others.

Conclusions

Gastric polyps are a rare entity, often found incidentally on upper gastrointestinal endoscopy. The majority of gastric polyps are asymptomatic but they often present with occult GI bleeding or partial gastric outlet obstruction. A gastrotomy was an effective choice of treatment, considering the polyp size, and potential for malignancy, as opposed to an endoscopic approach.

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