

Perforated gastric diverticulum with bleeding

A 42-year-old man presented with a 3-day history of epigastric pain and tarry stools. On physical examination the hemodynamics were stable, and the patient had a pallor and mild epigastric tenderness. Blood tests revealed a hemoglobin level of 7.7 g/dL, and a chest X-ray showed a rim of free gas under the diaphragm. On abdominal computed tomography, focal dilatation was noted over the greater curve of the stomach, exaggerated by the presence of organized debris with hyperdensities suspicious of blood or food particles (● Fig. 1). In view of his stable condition, the patient was treated conservatively. However, on follow-up esophago-gastroduodenoscopy (EGD) 2 weeks later, a 4-cm outpouching, containing small amounts of coffee-ground substances and food residue, was noted on the greater curvature of the stomach (● Fig. 2). Overall, the features were suggestive of a gastric diverticulum that had previously bled and was perforated. The patient underwent laparoscopic-stapled diverticulectomy, and pathological examination revealed gastric mucosal herniations without muscular coating, compatible with a false diverticulum of the stomach. Gastric diverticulum is a rare diverticulum with around 200 cases reported in the literature [1], with a prevalence between 0.01% and 0.11% [2,3]. There is no gender predilection and the presenting age ranges from 20 to 60 years. Most individuals remain asymptomatic but complications such as bleeding and perforation can occur [1,2,4]. Gastric diverticula can be congenital or acquired [5]. The congenital diverticula are true diverticula and account for 72% of all cases [4]. They are usually within 2–3 cm of the esophago-

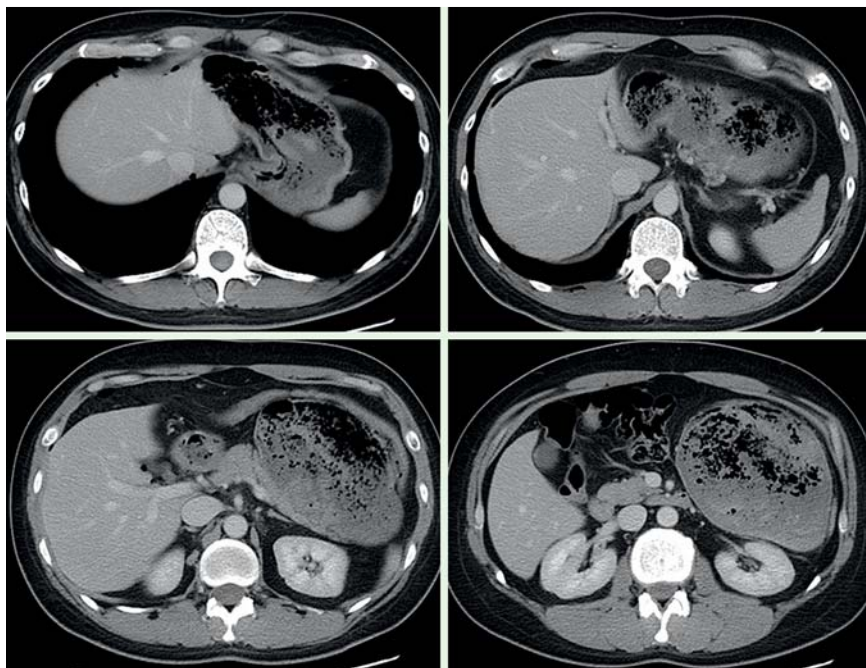


Fig. 1 Admission abdominal computed tomographic scan of a 42-year-old man with a 3-day history of epigastric pain and tarry stools.

gogastric junction and are believed to occur as a result of intrauterine malformation or interruption of fetal development. Acquired diverticula are false diverticula, containing only the gastric mucosa. These diverticula may be due to gastric outlet obstruction, repeated vomiting, acute cholecystitis, pancreatitis, or hepatic or splenic adhesions. Surgical resection is the recommended treatment in symptomatic patients, with laparoscopic diverticulectomy being the preferred approach.

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AF

Competing interests: None

**M. F. Ho, A. Y. Teoh,
S. Y. Liu, P. W. Chiu,
S. K. Wong, E. K. W. Ng**

Division of Upper Gastrointestinal Surgery,
Department of Surgery, Prince of Wales
Hospital, Chinese University of Hong Kong,
Hong Kong SAR, China

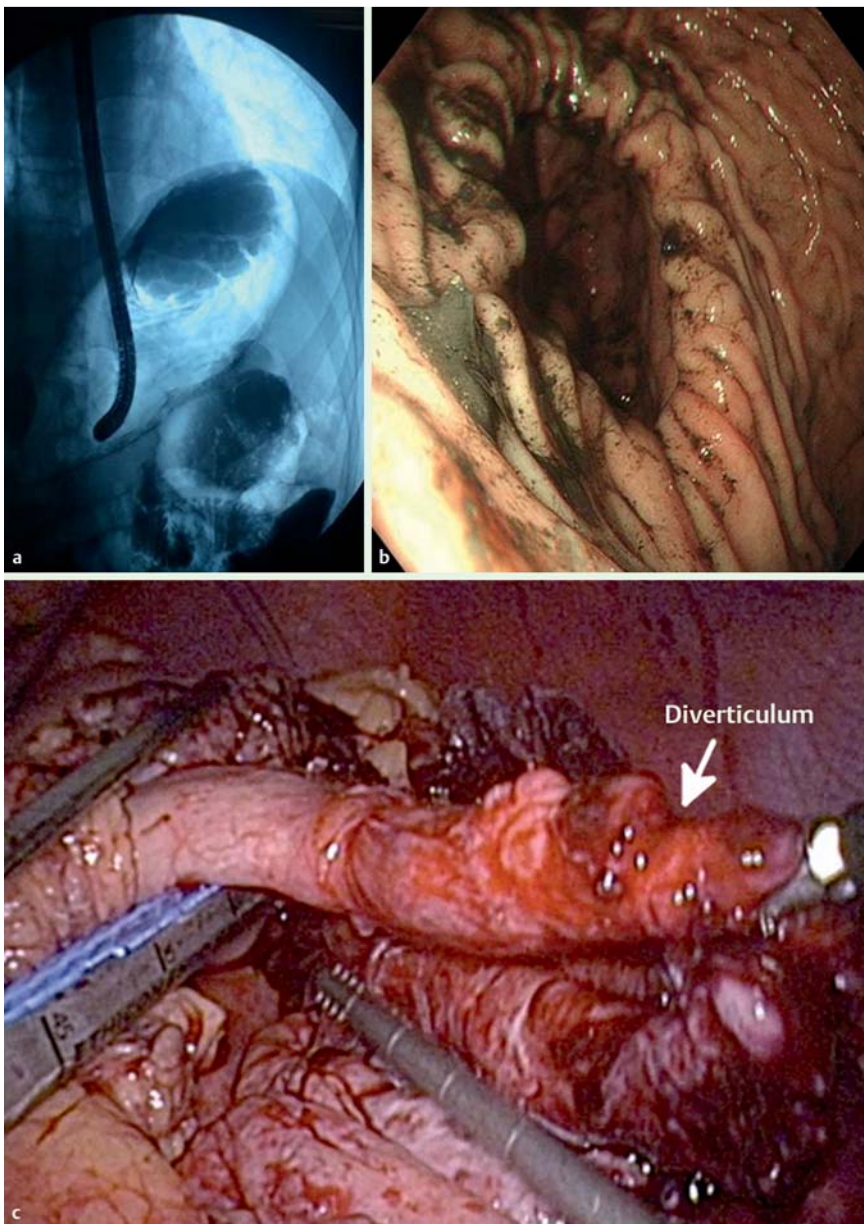


Fig. 2 Appearance of the gastric diverticulum: **a** radiological; **b** endoscopic; **c** operative.

References

- 1 Cotea E, Vasilescu A, Dimofte G et al. Gastric diverticula on the greater curvature. *J Chir* 2007; 3: 269–273
- 2 Palmer ED. Collective review: gastric diverticula. *Int Abstr Surg* 1951; 92: 417–428
- 3 Donkervoort SC, Baak LC, Blaauwgeers JL et al. Laparoscopic resection of a symptomatic gastric diverticulum. *JSL* 2006; 10: 525–527
- 4 Rodeberg DA, Zaheer SR, Moir CR, Ishitani MB. Gastric Diverticulum: A Series of four pediatric patients. *J Pediatr Gastroenterol Nutr* 2002; 34: 564–567
- 5 Schmidt HW, Walters WL. Diverticula of stomach. *Surg Gynec Obst* 1935; 60: 106

Bibliography

DOI <http://dx.doi.org/10.1055/s-0033-1353616>
 Endoscopy 2013; 45: E422–E423
 © Georg Thieme Verlag KG
 Stuttgart · New York
 ISSN 0013-726X

Corresponding author

E. K. W. Ng
 Department of Surgery
 Prince of Wales Hospital
 The Chinese University of Hong Kong
 New Territories
 Hong Kong
 Fax: +852-2637-7974
endersng@surgery.cuhk.edu.hk