A 24-year-old male patient presented with abdominal pain and recurrent vomiting for a week. The patient was asthenic with a body mass index of 20.1 kg/m². There was no evidence of generalized lymphadenopathy. On per-abdominal examination, a lump of around 5 cm was palpable in the right hypochondrium extending into the right lumbar region, which was not moving with respiration. There was no hepatosplenomegaly. A succussion splash was heard on auscultation. Upper gastrointestinal endoscopy revealed a grossly dilated stomach and first and second parts of the duodenum (D1 and D2) with luminal narrowing at D2-D3 junction. Biopsy revealed lymphoplasmacytic infiltration of the lamina propria. Computed tomography of the chest and abdomen was done that showed ill-defined hypodense lesion posterior to D2 and grossly distended stomach and D1 (►Fig. 1A and 1B). Ultrasound-guided fine needle aspiration (FNA) from the mass showed predominant necrosis with a few granulomas in a background of mature lymphoid cells. Ziehl–Neelsen staining revealed the presence of acid-fast bacilli suggestive of tuberculosis (►Fig. 1D and E). Intraoperatively, there was a mass in the D2-D3 region with a grossly dilated stomach (►Fig. 1C), and no peritoneal or omental deposits. Isoperistaltic ante-colic gastrojejunostomy was done along with feeding jejunostomy. The post-operative course was uneventful, the patient was allowed orally by postoperative day (POD) 3 and was discharged on POD5. Following discharge, he was started on antitubercular therapy (ATT) for 6 months. Currently, at 2 year follow-up, the patient is doing fine and has no similar complaints.

This case is reported because of the unusual presentation with gastric outlet obstruction. Gastric outlet obstruction is usually a result of gastric cancer or peptic ulcer disease. Tuberculosis can result in GOO due to the involvement of antro-pyloric region, duodenal tuberculosis, and rarely extrinsic compression by lymphadenopathy, as noted in the present case.²

Ethical Statement
Ethical approval was taken from the institute’s ethics board. Written consent was obtained from the patient.

Author Contributions

Data Availability Statement
There is no data associated with this work.
Fig. 1  (A) Coronal CT scan showing grossly dilated stomach (asterisk). (B) Axial CT scan image showing the retroperitoneal lymph node (arrow) causing extrinsic compression of the duodenum (D2-D3 junction). (C) Intra-operative image showing grossly dilated stomach (asterisk). (D) Ultrasound-guided fine needle aspiration cytology smear showing extensive caseous necrosis (inset shows acid fast bacillus) May Grünwald–Giemsa stain, Inset: Ziehl–Neelsen stain. (E) Epithelioid cell granuloma in hematoxylin and eosin stain.

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Conflict of Interest
None declared.

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References