

A 58-year old man who was undergoing treatment for an oropharyngeal carcinoma was experiencing significant dysphagia and underwent endoscopy for placement of a percutaneous endoscopic gastrostomy (PEG) tube. Examination of the stomach revealed superficial erosions consistent with mild antral gastritis, and a double-pylorus deformity was identified (Fig. 1).

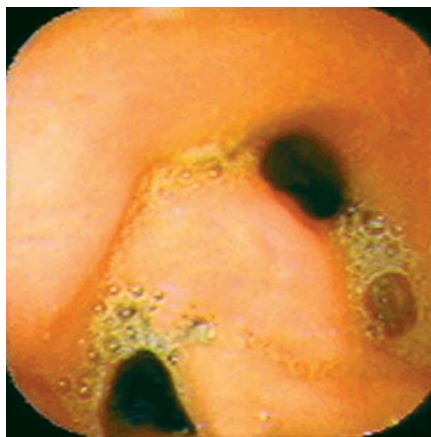


Figure 1 Double pylorus observed in a 58-year-old man during endoscopy for placement of a percutaneous endoscopic gastrostomy.

A 57-year-old man with a remote history of peptic ulcer disease presented for endoscopy with a 2-month history of intermittent epigastric abdominal pain. Examination of the stomach revealed a double-pylorus deformity (Fig. 2).

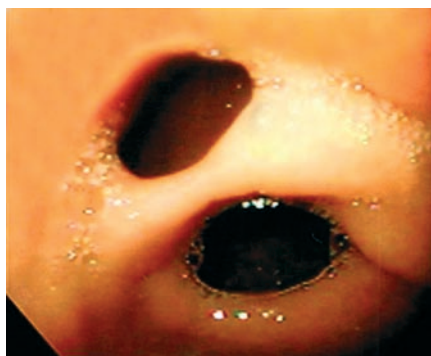


Figure 2 Double pylorus observed in a 57-year-old man undergoing endoscopy due to abdominal pain.

During upper gastrointestinal endoscopy, the discovery of two pyloric ostia leading into the duodenum, also known as double pylorus, is a rare and surprising finding that has been reported in 0.001–0.4% of procedures [1]. In a review of 60 cases of double pylorus, Eschar et al. found that the mean age of the patients was 59.6 years (range 28–89 years) and that double pylorus was more common in men (62%) [1]. The underlying etiology of double pylorus is either congenital or acquired. A diagnosis of congenital DP depends on both channels having normal histology, with no signs of antroduodenal ulceration or inflammation. Acquired double pylorus is more commonly observed, and arises from ulceration and fistulization between the gastric antrum and duodenal bulb; not all of the normal histological layers are present in this form [2]. Less commonly, double pylorus can arise due to ulceration from a gastric or duodenal malignancy that eventually becomes a fistula [3]. Not surprisingly, many patients with double pylorus present with a long-standing history of symptomatic peptic ulcer disease [1,2]. In contrast swallow studies, double pylorus appears as two channels of barium separated by a smooth radiolucent band of soft tissue. At endoscopy, the gastric antrum may appear normal (as in the present two cases), inflamed, or ulcerated [4]. The fistula may

vary in size from a few millimeters to several centimeters, and usually extends from the lesser curvature of the stomach to the superior aspect of the duodenal bulb [5]. Irregularity in the region of the fistula should prompt multiple directed biopsies to rule out malignancy. From the gastric antrum, visualization of a biopsy forceps or catheter that has been passed through the fistula and is observed to enter the pylorus has been described as offering a useful technique for diagnosing double pylorus [5].

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