Acute gastric volvulus: A case report

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CASE REPORT

An 87-year-old female patient, with previous history of high blood pressure, came to the Emergency Department with complaints of intensive abdominal pain in the last 24 hours, associated with nausea without vomiting. Physical examination determined blood pressure: 120/60 mmHg, heart rate: 110/min, none diuresis, abdominal distension and epigastric pain without signs of peritonitis. Lab report: 12,900 leukocytes/µL (90 % neutrophils), creatinine level: 3 mg/dL, urea level: 90 mg/dL. A nasogastric tube was inserted and abundant gas was obtained through it. Thorax and abdomen radiography scan were made (Figs. 1 and 2). A CT-scan was also performed (Fig. 3). This patient underwent an emergency laparotomy and a complete gastric necrosis was found (Fig. 4). A total gastrectomy was initiated but the patient suffered an intraoperative cardiac arrest. Finally, the patient died in spite of cardiopulmonary reanimation.
DISCUSSION

Gastric volvulus (GV) is an uncommon disease which can be life threatening. Its incidence is unknown, due to a mild intermittent and chronic type of this disease. GV involves the rotation of more than 180° of the stomach in its organoaxial axis (59 %), in its mesenteroaxial axis (29 %), or both (2 %) (1). It causes ischemia of the stomach, and, if not recognized early, it can lead to gastric necrosis. It is important to note that necrosis of the stomach is infrequent, due to its rich blood supply, but when it appears, the mortality rate is approximately 30-50 % (2). The etiology is secondary to diaphragmatic defects in the 70 % of the cases, with paraesophageal hernia being the main cause (3). Classic symptoms of acute GV are known as Bochardt’s triad (severe epigastric pain, nonproductive vomiting and inability to pass a nasogastric tube) (4) and they appear in 50 % of the cases (5). Diagnosis is usually done by CT-scan, although diagnostic signs will show up in a plain X-ray. Plain radiographic findings include an intrathoracic portion of the stomach, severe gastric distension and lack of air in the distal bowel. The main treatment is surgical and includes laparotomy, gastric detorsion, repair of associated diaphragmatic hernia and fixation or anterior gastrostomy. Gastrectomy is indicated in cases of gastric necrosis (5). The endoscopic approach alongside percutaneous gastrostomy is the treatment of choice for high risk patients without gastric necrosis (6).

REFERENCES