

Title:

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Ischemic gastritis and severe diabetic ketoacidosis

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Dear Editor,

Ischemic gastritis (IG) is an extremely rare entity due to the rich gastric vascularization¹. The present case is the ideal setting to suspect it.

A 55-year-old man with hypertension, dyslipidaemia, ischemic heart disease, and type 1 diabetes mellitus (DM) with diabetic retinopathy and nephropathy. Under treatment with Clopidogrel, ASA, Atorvastatin, Ramipril, Omeprazole and insulin therapy.

He was brought to the emergency room with Glasgow Scale 5 so he was admitted to the ICU.

Venous blood gases analysis on admission showed pH 6.96, pCO₂ 33.6 mmHg, pO₂ 120 mmHg, HCO₃ 8 mmol/L and glucose 780 mg/dL.

After a diagnosis of severe diabetic ketoacidosis, intensive fluid therapy and insulin infusion were started.

At 24h he started with melenas. Gastroscopy showed a clearly delimited 7cm blackish fundus mucosa, with a necrotic and ulcerated appearance (biopsy). This area presented sheet bleeding treated with Hemospray (Figure 1A-B). A noncontrast abdominal CT scan was performed due to high suspicion of IG, detecting gastric and portal system pneumatosis (Figure 1C-D).

It was decided to continue with conservative treatment since the bleeding was self-limited. He presented progressive metabolic stability and was discharged after 15 days.

The pathology examination confirmed findings compatible with IG.

The most common causes of IG are vascular², especially of atherothrombotic origin.

Our case presented several macro/microvascular complications of DM.

The main symptom is abdominal anginal pain. Before admission, the patient had postprandial abdominal pain. This finding and the absence of other triggering causes, leads us to believe that the origin of diabetic decompensation was IG.

Highlight the possible interaction between Omeprazole and Clopidogrel, decreasing the antiaggregant power of the latter^{3,4,5}. In our case we replaced Omeprazole for Pantoprazole, separating the dose between Pantoprazole and Clopidogrel by 12 h⁴.

REFERENCES

1. Quiñones Castro R, Vaquero Ayala L, Álvarez Cañas MC. Ischemic gastritis due to oral iron. *Rev Esp enfermedades Dig organo Of la Soc Esp Patol Dig.* 2019;111(12):971-972. doi:10.17235/reed.2019.6401/2019
2. Elwir S, Shaukat A, Mesa H, Colbach C, Dambowy P, Shaw M. Ischemic Gastritis: A Multicenter Case Series of a Rare Clinical Entity and a Review of the Literature. *J Clin Gastroenterol.* 2016;50(9):722-726. doi:10.1097/MCG.0000000000000468
3. Gilard M, Arnaud B, Cornily J-C, et al. Influence of omeprazole on the antiplatelet action of clopidogrel associated with aspirin: the randomized, double-blind OCLA (Omeprazole CLOpidogrel Aspirin) study. *J Am Coll Cardiol.* 2008;51(3):256-260. doi:10.1016/j.jacc.2007.06.064
4. Laine L, Hennekens C. Proton pump inhibitor and clopidogrel interaction: fact or fiction? *Am J Gastroenterol.* 2010;105(1):34-41. doi:10.1038/ajg.2009.638
5. Ho PM, Maddox TM, Wang L, et al. Risk of adverse outcomes associated with concomitant use of clopidogrel and proton pump inhibitors following acute coronary syndrome. *JAMA.* 2009;301(9):937-944. doi:10.1001/jama.2009.261

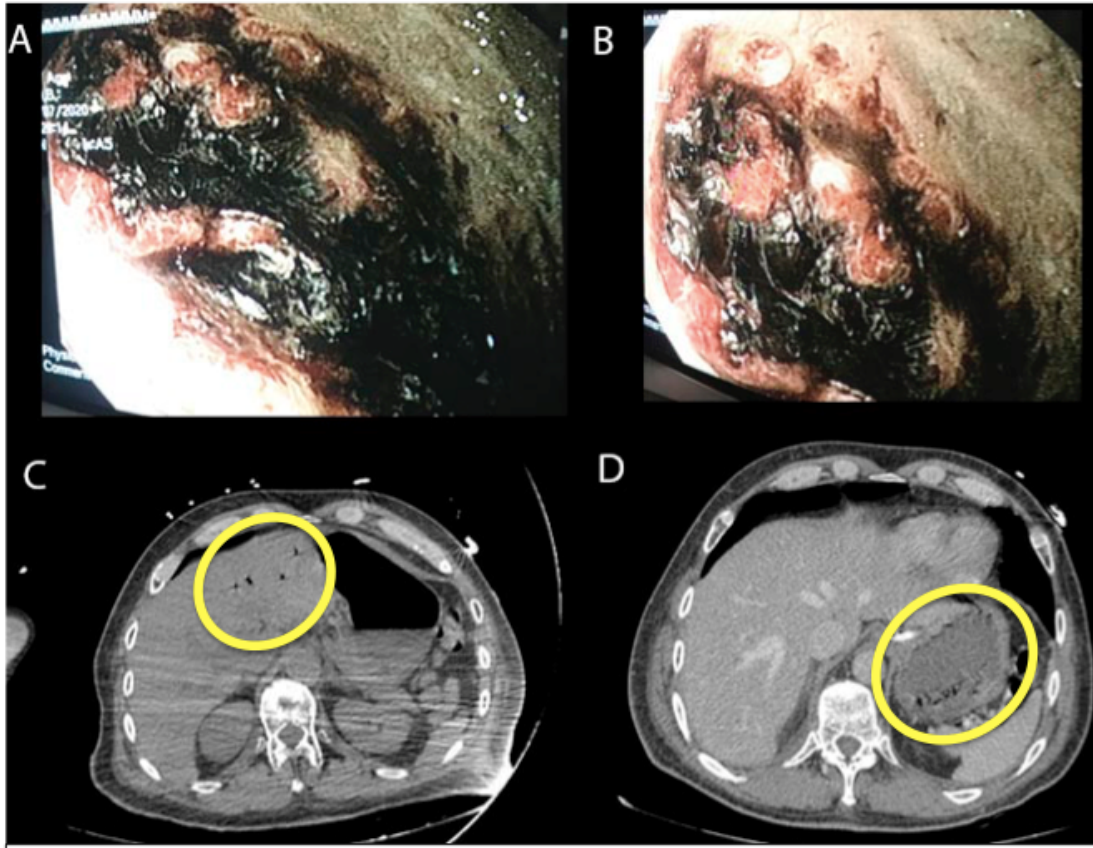


Figure 1. Gastroscopy (A-B): Clearly delimited blackish and necrotic area with surrounding healthy mucosa. Sheet bleeding treated with Hemospray due to extreme friability. **Noncontrast abdominal CT scan:** We see gas in the portal system, predominantly in the left liver lobe (C) and the wall of the gastric fundus significantly edematous with air bubbles in its thickness (D).