

Title:
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Carta 8528 inglés

Gastric ulcer with liver penetration

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Dear Editor,

A 54-year-old male with a previous history of chronic hepatitis C complained of postprandial epigastric discomfort and weight loss. Esophagogastroduodenoscopy revealed a large gastric ulcer on the lesser antral curvature (Fig. 1A), with biopsies showing granulation tissue and inflammatory activity without other significant changes. Despite therapy with double-dose proton pump inhibitor, the symptoms did not improve and the ulcer had not healed or diminished in size at the reevaluation endoscopy eight weeks later. Biopsies were repeated and again, only revealed granulation tissue and inflammation. The ulcer was deemed medically refractory and the patient underwent a partial gastrectomy where fibrotic adhesions to liver and peritoneum were noted intra-operatively. Remarkably, macroscopical analysis of the surgical specimen revealed a hepatic fragment adherent to the ulcer and

histopathological examination revealed epithelial loss of continuity extending to the hepatic parenchyma (Fig. 1B) and transmural fibrosis penetrating liver tissue (Fig. 1C), consistent with liver penetration. The patient improved after surgery and remains asymptomatic after two years.

Gastric ulcer penetration into the liver is a rare event, usually presenting with abdominal pain or gastrointestinal bleeding (1). The usual endoscopic appearance is a large gastric ulcer with a deep fibrin-covered base and the diagnosis is usually established by biopsies (2). Nevertheless, in our case, biopsies were performed more than once without evidence of liver tissue. A previous case that was unexpectedly found at surgery, was also preceded by endoscopy where biopsies were hard to obtain as the ulcer base was too thick (3). We can therefore hypothesize that it may be difficult to obtain adequate tissue samples of the hard liver surface with conventional biopsy forceps and endoscopic biopsies may have a low sensitivity for this complication.

In conclusion, liver penetration is a rare but important complication that must be considered in the differential diagnosis of medically refractory gastric ulcers, even in the absence of hepatic tissue in endoscopic biopsy

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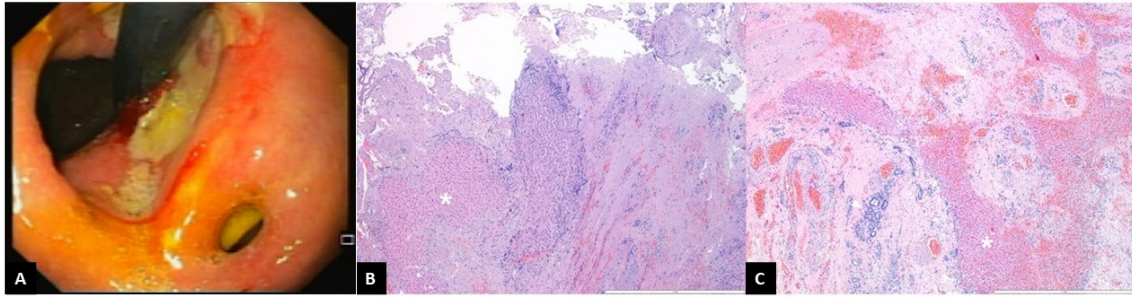


Figure 1. A. Upper digestive endoscopy revealed a large gastric ulcer (25 mm) at the lesser curvature of the antrum, with the base covered with fibrin. B. Histopathological examination revealed a loss of continuity of the gastric epithelium extending to hepatic parenchyma (asterisk) (HE, $\times 40$). C. A higher amplification demonstrated hepatic tissue as groups of hepatocytes (asterisk) and biliary ducts (arrowhead) surrounded by fibrosis (HE, $\times 100$).