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Carta 8543 inglés

Perforation of a decubitus gastric ulcer during intragastric balloon retrieval after surreptitious withdrawal of omeprazole

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Conflict of interest: the authors declare no conflict of interest.

Keywords: Intragastric balloon. Gastric ulcer. Perforation. Decubitus. Obesity.

Dear Editor,

The case was a 24-year-old male, obesity class-1 (BMI 30.12 kg/m^2), with no comorbidities. He presented to our Obesity Unit (June 2019) and a 6-month intragastric balloon (IGB) (Medsil, Moskovskaya Oblast, Russia) filled with 550 ml of serum was placed. He remained asymptomatic and maintained a correct adherence to nutritional counseling for four months. In October, the patient had lost 13 kilograms (TBWL: 15.2 %), remained asymptomatic and was taking PPIs. The next month he referred the onset of intermittent epigastric pain, after abandoning omeprazole due to his own choice. The abdominal examination was normal and he restarted liquids and lansoprazole. A few days later, he was admitted to the Regional Hospital due to continuous epigastralgia, radiating to the back, with vomiting. Abdominal examination, ECG and X-rays showed no findings. A CT scan showed gastric wall thickening but no perforation signs. The patient was transferred to our hospital for IGB removal (TBWL: 17.6 %; BMI 24.8 kg/m^2). Esophago-gastro-duodenoscopy (Fig. 1) showed intact IGB and fundal food remains. Puncture-aspiration in retroflexion and visualization of a deep gastric ulcer (Fig. 1A) in the upper body was suggestive of a pressure ulcer. Insufflation was decreased, recovering a frontal approach from the cardia for retrieval. Suddenly, a soft tissue mass, compatible with the omentum, rose up to the esophagus (Fig. 1B). Simultaneous abdominal distention suggested ulcer perforation. The endoscope was removed and he underwent an urgent laparotomy that confirmed the existence of a perforated ulcer in the anterior wall of the gastric body (Fig. 1C). IGB retrieval by perforation hole, minigastrectomy, omentoplasty and peritoneal lavage were performed and the patient was discharged four days later, as he was asymptomatic. The pathology analysis diagnosed a pressure ulcer.

Discussion

This case serves to emphasize that, although IGB achieves good results with a good safety profile (1), it is not exempt from serious complications such as perforation, necrosis or intestinal occlusion (1-3). We must warn about it and demand scrupulous compliance with the prescribed treatment, following expert recommendations (4,5). The surreptitious withdrawal of PPIs by our patient caused the ulcer and subsequent perforation.

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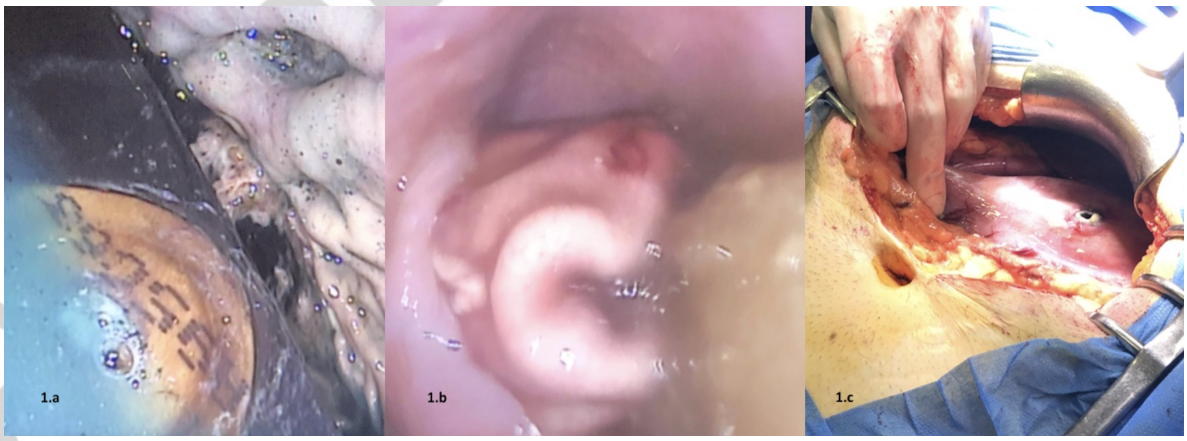

Fig. 1. During balloon removal, a deep ulcer was visualized after IGB deflation in the gastric upper body (A). Approaching the balloon from the cardia, a soft tissue mass, omentum-like, rises through the cardia to the esophagus (C). The patient underwent a laparotomy that

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confirmed the necrotic gastric ulcer in the anterior wall of the proximal body.