

Endoscopic Discovery of Asthenic Peritonitis Due to Gastric Perforation: About A Case at The Teaching Hospital Center of Kara (CHU KARA)

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ABSTRACT

Authors report a case of asthenic peritonitis due to gastric perforation, discovered during upper endoscopy, performed at CHU Kara.

It was about a 57 years old patient, alcoholic and tobacco addict who presented a chronic epigastric pain that has been progressing for 6 months, treated in the traditional way without improvement. There has been an exacerbation of the pain for 3 months, associated with intermittent vomiting; containing food debris and significant weight loss (8 kilograms for 03 months). Esogastroduodenal fibroscopy revealed a large tumor-like antral injury with a large oval perforation of approximately 30 mm in the breast. Histological examination of the biopsies revealed moderate differentiated adenocarcinoma and the presence of Helicobacter pylori. The patient has been immediately referred for surgery where he underwent a 4/5 gastrectomy associated with a peritonitis cure. The postoperative period has been marked by death, from a septic shock.

Keywords

Peritonitis, Gastric perforation, Endoscopy, Surgery, Togo.

Introduction

Gastric perforation is a medical-surgical emergency that can complicate peptic gastroduodenal ulcers. It often manifests as overt peritoneal irritation syndrome. However, in some areas, symptoms can be minimal, suggesting an asthenic peritonitis. We report a rare case of chronic gastric perforation, discovered during endoscopy in a 57 old patient at the teaching hospital center in Kara.

Observation

This is a 57 old patient, received for endoscopy, because of chronic ulcer pain that has been progressing for 6 months. The patient has mostly benefited from a traditional treatment with no pain regression. This pain has been increased for about 3 months, associated with intermittent coffee-colored vomiting, that contained food debris and hardly relieved the pain. There was significant

weight loss (8 kilograms for 3 months), and no fever. Physical examination on the endoscopy table revealed epigastric tenderness and severe malnutrition. As antecedents, he has suffered from chronic epigastralgia for more than 5 years, never explored; with a notion of melena. He has also been a chronic tobacco user for 25 pack-years (during 30 years), and chronic ethyl (not quantified).

The esogastroduodenal endoscopy revealed a large tumor of the antrum (Figure 1), invading the angulus with partial pyloric stenosis. We also visualized a large perforation of about 30 millimeters within this lesion, with an opening in the peritoneal cavity (Figure 2). The esophagus, cardia, fundus, bulb and 2nd duodenum were regular. The biopsies has been taken on the edges of the lesion (that was hard and cardboard under the biopsy forceps) for histological examination. Anatomical pathology examination revealed a poorly differentiated adenocarcinoma, associated with chronic gastric Helicobacter pylori.

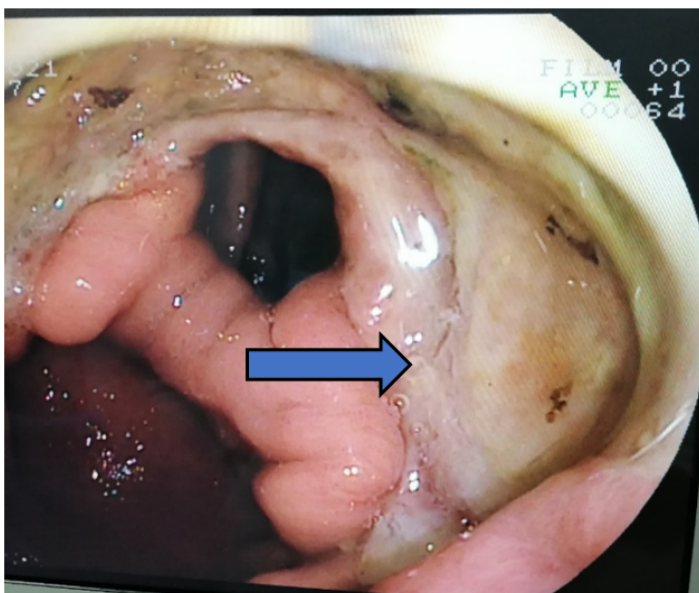


Figure 1: Tumor lesion (blue arrow).

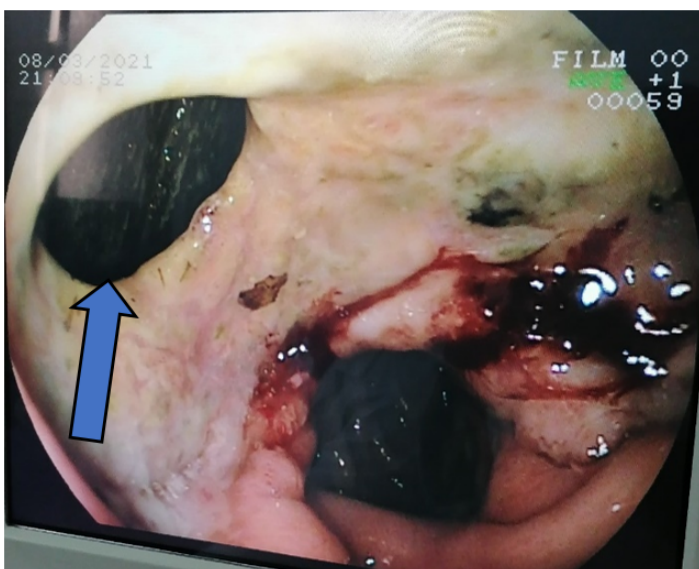


Figure 2: Oval perforation \approx 30 mm (Blue arrow).

The patient has been immediately hospitalized in the department of surgery and well-conditioned, then a preoperative and impact assessment was quickly carried out. This assessment found an inflammatory syndrome (CRP = 80 SR = 32 WBC = 14400 HL = 10.5 g/dl, Azotemia = 0.46 g/l, Serum creatinine = 15 mg/l; the blood ionogram was normal.

The patient has been immediately operated. The laparotomy revealed a stenosing antro-pyloric mass, perforated within it, with perigastric nodes. He underwent a 4/5 gastrectomy with Finstertype, gastro-jejunal anastomosis and peritoneal toilet. The operative part was sent for histologic examination. The postoperative period was complicated with septic shock and death 48 hours later.

Discussion

Complications of peptic ulcers are: gastrointestinal bleeding, stricture, perforation and cancerization. The chronic evolution of epigastric pain, over several years in our patient seems to be in favor of a complicated chronic gastric ulcer. He has presented the four different types of complications. Cancerization is the most serious complication; evoked on the basis of the chronic evolution of the ulcer, the endoscopic features (Figure 1) of the tumor and especially, histological substantiation of the gastric adenocarcinoma. This ultimate complication of gastric ulcers occurs in approximately 3% of patients infected with *H. pylori* [1]. The role of this bacterium has no longer to be demonstrated in the genesis of peptic ulcers and gastric cancers. Globally, 50% of the population are infected with *H. pylori*; with some geographic variation [2]. The proportion of distal gastric cancers, attributable to *H. pylori* is estimated to 80% in developing countries [3]. Gastric perforation is common and complicates 2 to 11% of peptic ulcers [4,5]. It frequently appears as an acute peritoneal irritation syndrome. In contrast, our patient had chronic epigastric pain, not suggesting a surgical abdomen; because of the absence of peritoneal irritation signs, which explains the late diagnosis. The features of the perforation edges were suggesting a chronic lesion. The late performance of fibroscopy can also be explained by the scarcity of the digestive tract specialist doctors. In fact, there is only 2 hepatogastroenterologists for all the northern part of the country (2 075 843 people according to the 2010 national census data) [6]. The teaching hospital center of Kara (CHU Kara) is currently the only public structure in Togo with functional endoscopic equipment. Consequently, the access to endoscopic explorations is difficult for patients who have to travel from a region to another one in order to perform them. This promotes self-medication and traditional therapy, thus complicating the health of our patients. The major part of these street drugs contain nonsteroidal anti-inflammatory drugs (NSAIDs) which worsen damages of the digestive tract. The site of the lesion (antro-pyloric) explains the stenosis syndrome with vomiting. The leakage of part of the gastric contents into the peritoneal cavity could explain the absence of obvious gastric stasis. All of these complications described in our patient could also be linked to the association of several risk factors such as alcohol-smoking, *H. pylori* infection and the chronic use of NSAIDs. Upper gastrointestinal endoscopy makes pneumoperitoneum worse. In fact, it overestimates the diameter of the gastric perforation due to the insufflation, requiring wariness from the operator.

Conclusion

Peptic ulcer disease is a benign pathology that can become complicated (perforation, cancerization, gastrointestinal bleeding, stenosis), with an important role of *H. pylori* infection. The reduction of these complications requires a systematic exploration of any epigastric pain in an adult with detection and eradication of *Helicobacter pylori*.

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