ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 7, Issue, 07, pp.18607-18608, July, 2015

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

CASE REPORT

ISOLATED FUNDAL DIVERTICULA: A CASE REPORT

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ARTICLE INFO

Article History:
Received 23rd April, 2015
Received in revised form
20th May, 2015
Accepted 16th June, 2015
Published online 31st July, 2015

Key words:
Fundal diverticula,
Isolated, Upper GI endoscopy.

ABSTRACT

Gastric diverticula are rare in routine clinical practice. Diverticula are out-pouching from tubular structures. True diverticula involve all layers of the intestinal wall, whereas false diverticula are caused by herniation of mucosa and submucosa through the muscular wall. Gastric diverticula are mostly asymptomatic. Most commonly the symptoms are upper abdominal pain, nausea and emesis, while dyspepsia and vomiting are less common. Ulceration with hemorrhage or perforation has been reported. Gastric diverticula are usually 1 to 3 cm in diameter. We present the case report of a middle aged man who came with complaint of indigestion, abdominal pain and bloating. On upper GI endoscopy he was diagnosed with gastric fundal diverticula.

***Citation*:** Dr Himanshu Khutan, 2015. "Isolated fundal Diverticula: A Case report", *International Journal of Current Research,* 7, (7), 18607-18608.

INTRODUCTION

A 50 year old, non-diabetic, non-hypertensive male presented with complaints of indigestion, pain abdomen and bloating. Pain was mild, continuous and used to increase after consuming meals. He denied any loss of appetite, weight loss, vomiting, hematemesis and melena. There was no history suggestive of abnormal bowel habits. Abdominal examination revealed no masses or other abnormalities; rest of the examination was also within normal limit. He is non-smoker and non-alcoholic. Baseline ECG was done which was invariably normal. His laboratory examination revealed normal complete blood count, liver and renal function test.An upper endoscopy was conducted, demonstrating isolated gastric fundal diverticula. Patient was put on proton pump inhibitors with which he improved symptomatically.

DISCUSSION

Moebius in 1661 and later Roax in 1774 first described gastric diverticula (Moses *et al*., 1946). Gastric diverticula are found in less than 1% of upper gastrointestinal x-rays or autopsies. Juxta-cardiac diverticula make up 75% of all gastric diverticula. These are most often located near the gastro-esophageal junction, on the posterior aspect of the lesser curvature of stomach. They are most commonly found in middle-aged patients, although cases have been reported in children and adolescents.

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They range in size from 1 to 3 cm in diameter (William *et al*., 2010). Two types of gastric diverticula are recognized according to Akerlund (Akerlund, 1923), and Schmidt *et al*. (1935): congenital (true) and acquired (false) diverticula. True diverticula involve all layers of the intestinal wall, whereas false diverticula are caused by herniation of mucosa and submucosa through the muscular wall. Intramural or partial gastric diverticula are formed by the projection of the mucosa of the stomach through the muscularis. These diverticula are found most commonly on the greater curvature. Deformities caused by peptic ulcers or other inflammatory processes can resemble prepyloric diverticula on barium studies or at endoscopy. Gastric diverticula have been reported as complication of obesity surgery (William *et al*., 2010). Juxtacardiac diverticula are almost always asymptomatic. Rarely, patients may complain of pain or dyspepsia attributable to a diverticulum. Reproduction of pain by probing the diverticulum with a biopsy forceps during upper gastrointestinal endoscopy has been reported (Anaise *et al*., 1984). Wide-neck diverticula often go unnoticed perhaps because food and digestive juices are less likely to become trapped. It has been suggested that food retention with subsequent distension of the gastric diverticulum may cause pain (Kilkenny *et al*., 1995; Tillander *et al*., 1968). During endoscopy, juxtacardiac diverticula are best seen on a retroflexed view. Juxtacardiac diverticula may be missed on barium study unless lateral views are taken (William *et al*., 2010). On CT scans, they may appear as air or contrast-filled suprarenal masses and can be mistaken for a necrotic adrenal mass (Verbeeck *et al*., 1994). Intramural diverticula require no

intervention. Juxtacardiac diverticula almost never need treatment. A clear association with a specific symptom complex should be firmly established before considering resection. Complications such as ulceration, bleeding, and cancer are very rare (William *et al*., 2010). If bleeding occurs, treatment may be challenging. The use of hemoclips has been reported (Lajoie *et al*., 2008). Surgical resection is the mainstay of treatment when the diverticulum is large, symptomatic or complicated by bleeding, perforation or malignancy, with over two-thirds of patients remaining symptom-free after surgery (Palmer *et al*., 1951). Our patient has a symptomatic gastric fundal diverticula. Timely detection and necessary intervention can prevent potential complications namely ulceration, bleeding and malignant transformation.

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